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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 22 1999

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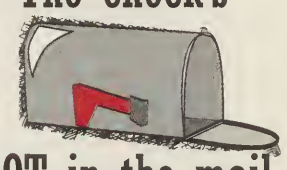

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Hastert steps up to speaker's plate

Linda Bartlett

AP/Wide World Photos

With his first rap of the gavel as House Speaker, U.S. Rep. J. Dennis Hastert (R-Ill.) launches a job he told Congress "I did not seek, but I embrace with determination and enthusiasm." Known for his accessibility and loyalty to his home state, Hastert's election as speaker is expected to be a bright spot for Illinois physicians. Hastert (top photo) met in Washington, D.C., last July with ISMS leaders to discuss managed care reform.

AMA attempts to foil Aetna's plans to acquire Prudential

Physicians fight formation of nation's largest HMO.

BY PAULA KRAPF

In an attempt to block Aetna U.S. Healthcare's hand, the AMA has asked the U.S. Department of Justice to thwart the company's $1 billion bid to purchase Prudential HealthCare and create the nation's largest health benefits provider.

ISMS promptly endorsed the AMA's move to protect patients and physicians from the harmful effects of insurance market concentration, said ISMS President Richard Geline, MD. "A truly free market needs true competition, not virtual monopolies."

"The market power that would be created or exacerbated by this merger would . . . further erode the ability of physicians to make medical decisions based on science and the medical needs of their patients, not share price," wrote E. Ratcliffe Anderson Jr., MD, the AMA's executive vice president, in a Dec. 18 letter to the DOJ's antitrust division.

Locally, the forecast for Rush Prudential Health Plans is unclear, because the plan is exempt from the Aetna-Prudential deal. Prudential has co-owned the Rush plan with Rush-Presbyterian-St. Luke's Medical Center since 1993. With nearly 400,000 members, the plan is metropolitan Chicago's fourth-largest HMO and is affiliated with 83 hospitals and nearly 10,000 physicians.

Aetna, for one, has expressed interest in purchasing the Rush plan. Rush reportedly is mulling three options: finding a new partner, purchasing the plan outright or selling out, although the terse statement the plan issued indicated that only two alternatives remain on the table.

"In due course, Rush Medical Center will decide how it wants to proceed, either becoming the sole owner of the health plan or selecting another partner to

(Continued on page 10)

Court rules medical staff bylaws form contract

ADVOCACY: Justices rely heavily on ISMS-backed law when making their decision.

BY JANE ZENTMYER

The 1995 economic credentialing law flexed its legal muscles for the first time this fall when the First District Appellate Court in Cook County issued a ruling favorable for physicians based on the due process guarantees included in the ISMS-backed legislation.

The appellate court's ruling stems from a case brought by Abel Garibaldi, MD, a cardiovascular surgeon, against the Blue Island-based St. Francis Hospital and Health Center and others. In this lawsuit, Dr. Garibaldi claimed that the hospital terminated his privileges in 1992 after it gave exclusive heart surgery rights to a physician group to which he didn't belong, and that the hospital failed to give him a hearing or written notice regarding changes to his hospital staff privileges.

The court determined that, by failing to give Dr. Garibaldi a hearing, the hospital governing board failed to follow the medical staff bylaws, which it said are a contract between the physicians and the hospital. As a result, the court sent the case back to the trial court to determine if the physician can collect monetary damages for the hospital's breach of contract.

"This decision is the most telling example of the value of the economic credentialing reforms ISMS pushed for in 1995," ISMS President Richard Geline, MD, said. "The court made it absolutely clear that the relationship between the medical staff and the hospital is contractual and that failure to comply with the terms of those bylaws could expose a hospital to monetary damages."

Economic credentialing, as defined in Illinois law, is the "use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing medical staff membership or privileges." The law establishes fair hearing proce-

(Continued on page 10)

Incentives plan remains on shelf

ISMS keeps pressure on Blues to back off of controversial policy.

BY PAULA KRAPF

Members of an ISMS committee met face-to-face on Jan. 6 with representatives from Blue Cross Blue Shield of Illinois to discuss their concerns with the company's controversial proposal to offer financial incentives to physicians who perform foot and ankle surgical procedures in their offices instead of hospitals and surgicenters.

"The word 'incentive' sounds like you're bribing physicians to take procedures from the hospital to the office," Biswamay

(Continued on page 10)

INSIDE

Report: Economic opportunity key to improving women's status

BY PAULA KRAPF

[CHICAGO] Improve economic conditions for women, and the barriers that thwart their access to essential services such as high-quality health care will crumble. That was the overriding conclusion of a report recently released by a state task force appointed by former Gov. Jim Edgar.

The report, Economic Independence for Women: An Action Plan for Illinois, suggests a series of short- and long-term strides government, as well as physicians and other private-sector representatives, can make to level the playing field for women.

"Even though the majority of women work and are primarily responsible for their families, there aren't enough support mechanisms to help them balance the demands of work and family," said Jane Jackman, MD, ISMS immediate past president and chairman of the health issues segment of the Governor's Commission on the Status of Women in Illinois, which authored the report after conducting a series of forums around the state.

Advances for women would benefit families overall because women are the primary caregivers, Dr. Jackman said. In addition to health issues, the report focuses on solutions to problems related to family violence, education, employment and child care.

Economic opportunity is the hub of the wheel of recommendations in the report, said Paula Wolff, commission chairman and president of Governors State University, as she unveiled the report at a Dec. 17 news conference.

"Solving the problems of women in Illinois solves the problems in Illinois, since as women suffer, so do their families," she said. There must be a permanent commission on the status of women in Illinois to oversee the recommendations, she added.

The administration of new Illinois Gov. George Ryan intends to turn many of the report's recommendations into policy, Lt. Gov. Corrine Wood said at the news conference.

Matt Ferguson

PAULA WOLFF, right, chairman of the Governor's Commission on the Status of Women in Illinois, unveils a long-range plan to improve opportunity for women at a Dec. 17 news conference in Chicago. Gov. George Ryan intends to institute many of the report's recommendations, said Lt. Gov. Corrine Wood, left.

The health agenda outlined in the report calls for increased access to care and treatment. "We were concerned, first of all, about the number of people who lack insurance," said Dr. Jackman. "The government and private employers should extend women's health insurance by expanding KidCare coverage, which currently serves poor children, to include families."

Approving health care reform legislation is a timely recommendation of the report. The task force's initiatives are similar to many of the components proposed in last year's failed managed care patient rights legislation, including bans on gag clauses, a means for patients to resolve grievances, legal liability for managed care plans, expanded patient choice of physician and continuity of care provisions if a physician leaves the plan.

Women's clinical health problems are identified as another critical area to address. Specific health-related goals in the report include:

- Establishing more practices in inner city and rural areas.
- Expanding telemedicine.
- Offering more education to help physicians recognize victims of abuse and provide appropriate referrals.
- Emphasizing preventive medicine. ■

CMS 1999 Midwest Clinical Conference features Gov. Ryan

Illinois Gov. George Ryan will be among the prominent local, national and international speakers featured at the Chicago Medical Society's 1999 Midwest Clinical Conference, to be held Feb. 26-28 at Navy Pier in Chicago.

Topics to be addressed at the conference include: accessing the Internet, clinical applications of cloning research, hospital governance and medical staff bylaws. Practice management topics include CPT coding for 1999 and the nuts and bolts of managed care. Gov. Ryan will be keynote speaker at the public service award luncheon.

Conference participants can earn up to 21 hours of CME credit. For more information or to register, call (312) 329-7341, or e-mail mcc@mcsdocs.org. ■

Annual Meeting approaches

The 1999 ISMS Annual Meeting will be held April 23-25 at the Oak Brook Hills Hotel, Oak Brook. County medical societies should submit a list of delegates and alternates to ISMS by Jan. 29. Resolutions must be received at ISMS headquarters by March 24. For more information, call (800) 782-ISMS.

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ISMS, AMA oppose sentinel event policy

BY PAULA KRAPF

Fearing that hospitals' sentinel event reports could become fodder for malpractice suits, ISMS and the AMA have requested a moratorium on implementation of the hospital accreditation standard until concerns are adequately addressed.

Sentinel events are defined as any unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Common examples include patient suicide, medication errors, wrong-site surgery, patient death and infant abduction. Under the Joint Commission on Accreditation of Healthcare Organizations' policy, hospitals should promptly report those events to the commission, and within 45 days perform a root cause analysis and develop an action plan. The JCAHO decides if the analysis and plan are appropriate; if not, the hospital could be placed under accreditation watch.

The JCAHO's sentinel event policy conflicts with and replicates a hospital's risk management functions, said ISMS President Richard Geline, MD. "Our concern is patient welfare: does this policy advance good patient care and the ability of doctors to deliver that care without adding more rules? That does not seem to be the case," he said.

Originally introduced in 1995, the sentinel events policy didn't receive much scrutiny from the medical establishment until last April, when JCAHO issued more stringent reporting guidelines for initiating root cause analyses and compiling action plans.

A resolution to oppose the sentinel event policy until JCAHO satisfactorily resolves confidentiality and other issues was introduced by the ISMS Board of Trustees and endorsed by the AMA's House of Delegates at its Annual Meeting last June.

In recent months, JCAHO's sentinel events policy has come under fire from physician and hospital organizations that contend the program places hospitals at legal risk if they voluntarily provide sentinel event information to a third party, in this case the commission. For instance, if a sentinel event leads to termination by the hospital, an attorney representing an employee could attempt to use information gleaned from the organization's root cause analysis or action plan on behalf of the plaintiff.

"Numerous attacks on the case law level have weakened laws protecting the discoverability of sensitive information such as a sentinel event report," explained Harold Jensen, MD, chairman of the ISMIE Board of Governors.

JCAHO, however, staunchly defends its policy. "Instead of the traditional knee-jerk reaction that simply punishes the caregiver when a medical error occurs, the sentinel event policy resolves the underlying breakdown in the system that can include poor training, lack of backup and inadequate procedures," said Chuck Mowll, JCAHO's executive vice president for government relations.

In one instance, after learning that several medical practitioners had incorrectly administered potassium chloride to patients, JCAHO urged hospitals to store vials of that chemical in their pharmacies so it wouldn't be confused with other concentrates, he said.

JCAHO also encourages hospitals to appoint a member of the commission to the organization's peer review or quality improvement committees or to identify JCAHO, in writing, as a participant in those processes.

Moreover, JCAHO has promised to pursue federal legislation that would provide greater confidentiality protection for medical documents such as root cause analyses, said Mowll.

Nevertheless, doubts linger regarding whether JCAHO has gone far enough to resolve the concerns about its sentinel events standard. "Those new policies haven't been tested in a court of law," Dr. Jensen noted.

Since introducing the standard in 1995, JCAHO has reviewed 351 sentinel events. Most of those incidents were reported in 1998 following a significant overhaul of the rules. Although self-reporting has dramatically increased, Mowll acknowledged that number would soar further if the confidentiality issues were satisfactorily settled. Mowll acknowleges some hospitals have chosen not to comply with the sentinel event policy.

Dr. Jensen attributed the rise in sentinel event reporting to hospitals' fear of losing their accreditation, on which their financial life depends.

"The immediate benefits of the sentinel event policy are less than readily apparent," added Dr. Geline. ■

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EDITORIAL

Strength in numbers works both ways

The giant – who goes by the name of Aetna Inc. – is poised to chow down another competitor. There appears to be no satiating this growing conglomerate, which just announced plans to buy Prudential Insurance Co.'s health plan operation. The acquisition will make Aetna U.S. Healthcare, at about 22.4 million members in 31 states, the nation's biggest private-sector health insurer and largest managed care plan.

This, of course, is not good news for physicians. Aetna is one giant who does not have good manners. As Aetna assets have grown through mergers and acquisitions in the past few years, so have its heavy-handed contract terms, negotiated with a take-it-or-leave-it attitude. An example frequently cited is its all-or-nothing contract that forces physicians who sign on with any local Aetna plan to take part in all of its plans – regardless of pay and terms.

While the mean giant swallows its latest meal and takes a nap to digest, physicians must develop and implement a strategy to fortify their own ranks.

Several options are available. Physicians, too, for example, can play the merger and acquisition game. Negotiating in a pack brings a force to the bargaining table that lone operators cannot achieve.

Unionization is yet another tactic physicians can use to strengthen their forces. 'Union' is sometimes considered a dirty word in the medical community, but for some physicians it may be a useful tool to counteract the forces of intensely consolidated payers, like Aetna.

Finally, sticking together through membership in organized medicine offers an excellent chance for survival. ISMS and the American Medical Association work tirelessly to lobby for and pass legislation that keeps giants like Aetna from trampling the rights of patients and physicians.

The AMA right now is flexing its muscle by throwing a roadblock in Aetna's plans – using its clout to stir up antitrust ideas with the U.S. Department of Justice.

"The market power that would be created or exacerbated by this merger would limit the choices of patients and employers, reduce competition and further erode the ability of physicians to make medical decisions based on science and the medical needs of their patients, not share price," AMA Executive Vice President E. Ratcliffe Anderson Jr., MD, stated in a letter sent to the DOJ.

Physicians should take note of these warnings as well. Strength in numbers can work to their advantage.

PRESIDENT'S LETTER

Courts appear willing to go where legislatures won't travel

Richard A. Geline, MD

When the [HMO] plan says "no," the doctor gets sued.

The matter of HMO liability has emerged as one of today's most contentious issues within the managed care reform debate.

Traditionally, the physician has been entrusted with both responsibility and authority for patient care. Gradually, as the managed care experiment continues, the concepts have separated. Although physicians remain responsible for delivering care, the authority they need to do so often shifts elsewhere.

HMO management has frequently aggregated to itself – rather than leaving to the treating physician – the authority to determine the medical necessity of a proposed treatment. This is tantamount to deciding whether or not patients get what their doctor thinks they need. Yet management has remained all too willing to leave the physician responsible for the adverse consequences of the misuse of that authority – when the plan says "no," the doctor gets sued. Correcting this imbalance is at the top of medicine's agenda.

In 1997 Texas became the first state to address the imbalance by passing a law that lets patients sue their HMOs. Immediately challenged by Aetna Inc. as contrary to the federal Employee Retirement Income Security Act, it was for the most part upheld by a federal court. The court agreed with physicians and others who argued that managed care accountability represents a public health issue on which states have a right to act.

Illinois and most other state legislatures have considered the matter; HMO accountability was a strong plank of the federal patient rights bill supported by the American Medical Association. With the exception of recent headway in Connecticut, intense political resistance from powerful business and insurance special interests – built on the dubious claim of increased costs – has stifled this legislation beyond Texas and Missouri.

As this battle rages across the legislative front, a second skirmish is being waged in a court system apparently more willing than legislatures to recognize the public health threat posed by managed care's assumption of authority without responsibility.

An Illinois appellate court recently reinstated a case against an HMO that a lower court had dismissed. The patient, suing doctors and a hospital over a late cancer diagnosis, included the HMO on the premise that vicarious liability existed under the theory of apparent agency.

The HMO's defense was quite straightforward: the doctors and hospitals were independent contractors and not employees or agents of the HMO. But the appellate court said, "apparent agency of an HMO can be established by showing that the HMO by its actions or statements led a third party . . . to believe that the physicians were controlled by the HMO."

There is little precedent for this case in Illinois, but there are some relevant decisions elsewhere. A Pennsylvania court ruled in a similar case that there existed an inference that the patient looks to the institution (HMO) for care and not solely to the physician.

The Illinois court found a genuine issue of material fact as to whether the HMO held its physicians out to be its apparent agents and whether the patient reasonably relied on those representations. The court agreed with the patient's argument that HMOs should not be allowed to portray themselves in aggressive advertising campaigns as total providers of health care and then seek to avoid liability based on a disclaimer buried deep in the contract.

This matter is currently under review before the Illinois Supreme Court. What seems so elusive in the legislative arena may be nearly at hand in the case law.

GUEST EDITORIAL

Elderly being used as pawns in health care debate

By Joan Beck

The following report was one of the last articles written by newspaper columnist Joan Beck before she passed away on Dec. 9.

At least 96 HMOs in 30 states are dumping Medicare patients on Jan. 1, leaving almost half a million elderly people to find some other means of health care.

The dumping could be a callous effort by the HMOs to use the elderly as helpless pawns to force Congress and the administration to increase Medicare reimbursements. It may reflect the growing pains of a rapidly expanding industry. But most likely, the action is more evidence that the basic principles of managed care are flawed and no amount of tinkering is going to solve the problems.

The move comes just as the federal government is beginning a push to entice most Medicare recipients into some kind of managed care, like it or not. What's not clear is how many HMOs will be willing to sign on these elderly folks that the government wants out of basic Medicare.

In an effort to control costs, Congress last year passed a program called Medicare + Choice, intended to cut spending by shifting most of the elderly into some form of managed care. They are supposed to have the option of selecting an HMO, an HMO with a point-of-service option that allows a wider choice of out-of-network services, a preferred-provider organization set up by providers and run by hospitals and doctors, a private fee-for service insurance-type plan or a medical savings account. Or they could stay on basic Medicare itself.

So confusing are the choices, the government decided to limit its enrollment efforts to just five states for now – Arizona, Florida, Ohio, Oregon and Washington. But the drive is not going well. Information given to many seniors is sometimes out of date and unclear. And even before the new program gets under way, it's becoming obvious that many managed care organizations don't want the elderly.

A few years ago, many HMOs began wooing the healthiest elderly with selective recruiting, free eyeglasses, low-cost prescriptions and no need for buying a medigap policy, figuring Medicare reimbursements would more than cover their costs. But for many HMOs, it hasn't worked out well. Unlike the profitable, healthy workers who sign up for managed care through their employers and need only an occasional check-up or help with a sprained ankle or flu, most elderly people, sooner or later, develop expensive major or chronic illnesses and become a financial liability.

So some managed-care administrators, like good business executives, react by trying to get rid of their losses – the old people. (The elderly who are dumped can go back to basic Medicare, but will have more out-of-pocket costs and may have only a limited choice of medigap policies.)

In theory, managed care was supposed to apply business principles to health care, to eliminate unnecessary treatment, to standardize care and save money by forcing pharmaceutical companies to lower prices for bulk purchases of drugs. There was supposed to be enough fat to cut out of the system to provide good health care, pay executives huge salaries, cover a new layer of administrative costs, make profits high enough to impress Wall Street analysts and create shareholder value.

So far, managed care hasn't proved its case.

HMOs have helped to ratchet health care costs down in the last few years, in sharp contrast to earlier, steep annual increases. But the easy pickings are over. Many managed care organizations raised the cost of premiums to employers by as much as 7 percent this year and some have increases as high as 9 percent planned for 1999. Employers may react by passing higher costs on to employees or by agreeing to higher co-payments and fewer benefits.

". . .if you're the doctors' answering service why don't you have the answers?. . ."

Meanwhile controversy is growing about how managed care organizations have cut their costs.

Many physicians are rebelling against the tight controls on how they care for patients, on contracts that penalize them financially for sending patients to specialists or to the hospital, even for telling patients about expensive procedures or drugs that the HMO doesn't want to pay for.

Complaints abound about the difficulties in persuading HMOs to pay for expensive treatments and hospitalization, about refusals to reimburse for emergency room visits, about the frequent bureaucratic hassles involved in getting approvals for what seems to be essential care.

Such complaints have prompted a flood of new regulations by state legislatures. A patient's bill of rights measure will be high on the upcoming agenda of Congress. All of these add to the costs of managed care providers.

Already, many managed care groups are stretching out payments to hospitals and physicians (although they continue to give top executives multimillion-dollar salary packages). They are experimenting with mergers and acquisitions. Some try to avoid taking on money-losing patients, for example, by not signing up prominent specialists who would attract patients needing a lot of care. Even so, the costs of high-tech medicine are catching up with HMOs.

Perhaps it was unrealistic to expect that managed care organizations could control costs enough to pay for a new layer of administrators, reimburse doctors and hospitals fairly, provide all necessary treatment to a broad spectrum of people and make a profit for stockholders. It's going to be even more difficult when they are dealing with the elderly instead of healthy adult employees.

It's scary to have health care in the control of a profitmaking industry with the financial incentive to undertreat and deny care whenever possible and which has no qualms about dumping unprofitable clients. No one wants to think about rationing health care – and certainly no one wants it to be done as a matter of business profitability.

It's going to be a long and worrisome transition before we can all be sure that our health care will really be there for us when we need it. ■

Updated addresses needed for license renewal

Current medical licenses will expire on July 31, 1999, and renewal forms will be mailed in late spring. The Illinois Department of Professional Regulation is urging physicians who have moved in the past three years to update their addresses before March 1 to ensure prompt delivery of the license renewal forms.

Address changes must be submitted in writing. Please use the attached form to send your new address to the IDPR. Physicians wishing to change their address on an Illinois controlled substance license should contact IDPR for specific procedures.

For additional information, or for answers to questions concerning license-renewal procedures, contact the IDPR Licensure Maintenance Unit, 320 W. Washington St., 3rd Floor, LMU 1, Springfield, IL 62786; or call (217) 782-0458. ■

Physician address change notification form

License Number 036- **Date of Birth**

Name
Last **First** **Middle**

Social Security Number

Address

City **State** **ZIP**

Signature

MAIL TO:

Illinois Department of Professional Regulation, 320 W. Washington St., 3rd Floor, LMU 1, Springfield, IL 62786

Herbal remedy risks: What are your patients taking?

COMING SOON

ISMIE Update

After the split

Picking up the pieces when your managed care contract ends.

BY JANE ZENTMYER

The contractual marriage between physicians and managed care companies often causes a stormy relationship – one that can't weather frustrating negotiations, billing disagreements or hassles over appropriate medical procedures. When a divorce becomes necessary, physicians must move on without disrupting patient care or their own practice.

One legal pitfall that can arise from severed contracts is patient abandonment charges. A physician should never leave patients on their own to complete a treatment that has begun under the physician's care, said Henry Martin-del-Campo, MD, former medical director of the Peoria-based Methodist Medical Center.

To avoid patient abandonment charges, physicians must ensure that their patients who are connected to the terminated contract do not fall through the cracks. "Physicians need to advise patients to stay under their care or to transfer to another physician," he said.

For example, if a primary care physician is evaluating a lump in a patient's breast, and the contract with the patient's insurer is terminated during the evaluation period, that physician shouldn't assume the patient will follow up with another doctor, Dr. Martin-del-Campo said. Instead, the physician should help the patient find another doctor and communicate to that doctor the details of the patient's case.

Also, experts advise physicians to send their patients a letter alerting them to the impending termination of the doctor-patient relationship. The letter should explain that the physician will continue to provide care for 30 days – or whatever period of time the contract specifies – but the patient needs to choose a new physician to take over when that time expires. The letter can also be used to explain the requirements for transferring the patient's medical records to a new physician.

Written authorization is needed to release a patient's medical records; verbal requests are not sufficient, said Patricia Foltz, a partner with the Chicago-based law firm Lord, Bissell & Brook. "If a patient calls to request his or her records, the office staff should always explain that the physician is legally required to have written requests in the file," she said.

The patient's medical record should include documentation of the physician's efforts to ensure continuity of patient care. Then, if patient abandonment charges result in a trial, "physicians will have that record to demonstrate to a jury that they were caring and compassionate toward the patient," said Dr. Martin-del-Campo.

Also, physicians shouldn't wait until a contract is over to study the fine print. The best time for a physician to review a contract is before signing on the dotted line, explained Jeffrey O'Dwyer, a corporate health attorney with Lord, Bissell & Brook.

"The terms of any agreement will vary slightly, although most contracts contain boilerplate language," he said. If it's the managed care company that cancels the contract, physicians may want to find out why they were terminated and whether they were wrongly terminated, O'Dwyer said.

But, he noted that physicians' options will depend on the contract's terms: "Can legal action be taken? Or, does the contract allow the managed care company to eliminate the physician without an explanation?"

Other practice management steps that experts recommend physicians should take when the contract ends include the following:

- Evaluate financial status with the managed care insurer. "Sometimes physicians are owed money, and sometimes they owe money," O'Dwyer said.
- Review referral arrangements with other physicians or providers. Each party – the referring primary care physician and the specialist, for example – will have responsibilities that are outlined in their contracts. Communication between the two will give each side time to determine and fulfill their legal duties.
- Physicians may want to keep as many of the insurer's patients as possible; also, their contract may not prohibit them from competing for patients. Regardless of contract terms, "patients have a choice, and they typically will choose what makes the most financial sense for them," O'Dwyer said. "Most patients will switch to whatever physician the insurer will provide for them." ■

MALPRACTICE ROUNDUP

Case sounds warning about proper monitoring of physician's assistants

A Milwaukee case reported in the October 1998 issue of Medical Liability Alert serves as an excellent example of the risk physicians face in delegating responsibilities to a physician's assistant without properly monitoring the PA's work.

The malpractice action in Gonzalez v. Family Health Plan, et al., arose out of the death of a 45-year-old male bus driver from complications resulting from subacute bacterial endocarditis, which developed following a root canal.

As part of his enrollment in the Family Health Plan HMO, the plaintiff underwent a routine physical and history, which revealed the presence of a heart murmur. The HMO sent the plaintiff for a subsequent echocardiogram, which revealed a bicuspid aortic valve and regurgitation. This condition increases the risk for SBE from dental procedures, necessitating that such patients be given antibiotic prophylaxis before undergoing dental work. However, the patient apparently was not told of his condition or of the need for antibiotic prophylaxis.

Two months after undergoing a root canal, the patient presented to Family Health Plan with classic symptoms of SBE – night sweats, fatigue and chronic cough. He was seen by a PA, who made a note in the chart that the patient had previously had an echocardiogram showing the bicuspid valve with regurgitation. The supervising physician, however, did not read the PA's note. Court documents indicate he read the chart only to check for the patient's complaint and the PA's suggested treatment plan.

When the decedent began losing weight over the next two months, he returned to Family Health Plan in December 1994 and January 1995, when he was seen by another physician. During neither of those visits did the physician refer to the decedent's record, thus remaining unaware that the patient was at risk for SBE.

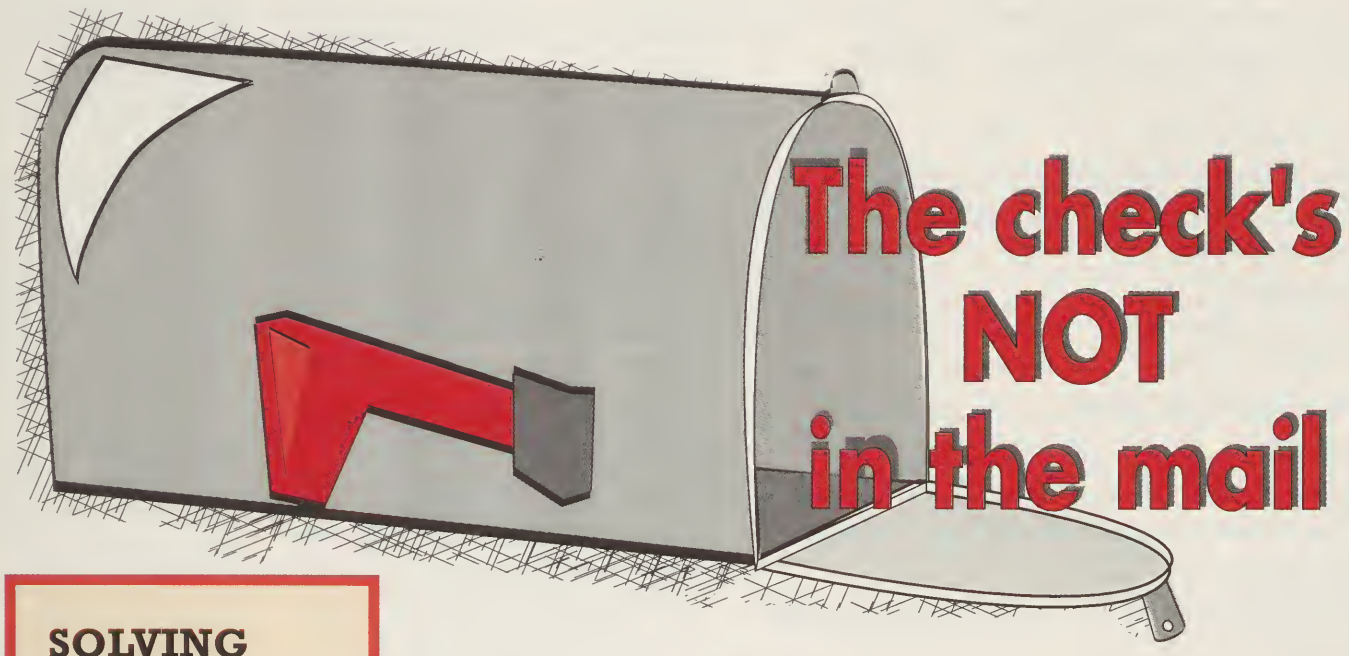
A month later, the patient died. An autopsy revealed that the infection had eroded through the aorta adjacent to the valve, causing massive bleeding and sudden death.

The plaintiff, the decedent's wife, contended that Family Health Plan was negligent on several counts: for not advising the patient of the results of the echocardiogram, for the supervising physician's failure to properly evaluate the PA's exam and note, and for the failure of the physician who saw the patient in December 1994 and January 1995 to obtain a proper history from the patient's chart.

The defendants settled shortly before trial in February 1998 for $1.2 million.

In the commentary following its discussion of the case, Medical Liability Alert reminds physicians of the importance of proper PA supervision: "Physician practitioners should be advised that when delegating some of their functions to a [PA], they are charged with all the history and information obtained by those assistants to whom they have delegated this function despite the fact that [they] may not have read the full information obtained by the assistant.

"Information obtained by a [PA] charged with the function of obtaining that information is chargeable to the delegating physician and does provide notice to him or her for liability purposes whether or not the physician actually read the particular information involved."



Julia Anderson-Miller

The check's NOT in the mail

SOLVING THE LATE-PAYMENT PUZZLE:

ISMS prepares to square off with carriers over delayed reimbursements.

BY JEFF BLACK

"I have $150,000 in receivables owed me by insurance companies. Today in the mail I got a check for $127. The day before, $100. Some days I don't receive a cent. Not one cent."

The speaker is G. Klaud Miller, MD, an orthopedic surgeon at Evanston's St. Francis Hospital, and he is not happy. Nor are many of his colleagues – Illinois physicians who find themselves near financial paralysis because, they say, insurance companies, Medicare and Medicaid are consciously and consistently late in reimbursing them.

"I have to pay my bills," Dr. Miller explained. "My malpractice [insurance] is still due. My rent is still due. My employees still want to be paid. If I have to pay my bills or face the consequences, why don't companies who owe me have to [pay] too?"

The Illinois State Medical Society has vowed to rectify the problem. However, it won't be easy. The Society predicts it will take a concerted team effort to solve the late-payment puzzle that creates frustration, helplessness and rage in many physicians.

The payment delays are no accident, according to Joel Blau, president of Mediqus Asset Advisors Inc. Carriers deliberately hold money due physicians in order to earn interest for themselves, he said. "The financial term for this is getting 'the float' out of the cash. Mostly we're talking about money market accounts where the interest is between three and five percent."

One published report, in fact, stated that nationally as of Dec. 31, 1996, the money owed all medical providers – including physicians and hospitals – by just three HMOs was a staggering $3.23 billion, a figure, experts say, that is even more massive today. It has been estimated a large HMO can currently earn up to $400,000 a day from interest off the float.

Illinois laws are of little help to physicians waiting for payment. Although the Illinois Department of Insurance receives physician complaints on this matter, "it does not arbitrate between a provider and a carrier," according to IDI spokeswoman Nan Nases. "There are no state statutes governing what constitutes timely payment," she said. Nases said that any such provisions are built into contracts between providers and carriers.

"The department's limited involvement in investigating late-payment cases usually takes place if an individual enrollee is being penalized for a carrier's failure to reimburse a provider," she said.

Nases did add, however, that "if the department received a rash of complaints against a particular carrier, we'd take a harder look at it."

Which is exactly ISMS' goal. To focus attention on the increasing problem of delayed payments by insurance companies, the Society has begun a stepped-up campaign of gathering details from

(Continued on page 8)

Is your mailbox empty?

ISMS wants to hear from physicians about the reimbursement delays they encounter. Please fill out this form to receive ISMS assistance collecting overdue payments. Data provided by physicians will also be used to compile evidence that ISMS can use in its campaign to reduce payment delays. Mail to: ISMS, Health Care Finance Department, 20 N. Michigan Ave., Chicago, IL 60602.

Name _____

Address _____

City _____

IL ZIP _____

Phone _____

Outstanding amount _____

How long is the payment overdue? _____

Is this hassle a: ❒ first-time problem ❒ recurring problem?

Identify organization causing the delay: _____

Type: Managed care ❒ Government ❒ Indemnity plan ❒ Independent Practice Association ❒

If possible, include documentation supporting your claim.

Late-payment

(Continued from page 7)

physicians on the reimbursement troubles they face. The names of specific carriers, amounts owed and length of payment delays are especially needed. The short form accompanying this article will help facilitate physicians in reporting the information; the Society will provide the results to appropriate state agencies, lawmakers and media.

The campaign is in part the result of a resolution passed in 1998 by the ISMS House of Delegates directing the Society to develop a strategy eliminating payment delays.

Richard Snodgrass, MD, chairman of the ISMS Third Party Payment Processes Committee, encouraged physicians to help the Society in this effort by forwarding their own anecdotal evidence of delayed payments.

"If we're going to respond appropriately to the House of Delegates' action, we need to document that there is a significant problem," he said.

He added that if it does turn out to be concentrated with one or only a few carriers, the IDI may need to get involved. But, he said, if it becomes clear this involves a majority of carriers, then change will be up to the Illinois legislature.

Psychiatrist Shastri Swaminathan, MD, who introduced the ISMS resolution, does not underestimate the wiliness of carriers, especially HMOs, in defying regulations. He suspects HMOs would sidestep a payment law by rejecting a claim out of hand, instead of facing a penalty. This tactic would allow the HMO to escape the deadline and delay payment even further.

One solution Dr. Swaminathan does support, however, would be to "front-load" delays.

"Make it part of any legislation that problems with a claim must be raised within two weeks of the carrier's receiving it," he explained. "If no problems are raised during that time, the payment must be made no later than four weeks after that."

Until the road to such legislation – or any solution – is traveled, what can physicians do to help their own cause? As a financial advisor to physicians, Blau reminds his clients to make sure a specific payment time frame is included in contracts signed with carriers. He also reminds them that everything in a contract is negotiable.

Yet physicians caught in a financial squeeze are sometimes hard-pressed to be optimistic. "You can't get blood out of a turnip," Dr. Miller said with a sigh.

Physicians who have experienced hassles in trying to collect payments can call ISMS at (800) 782-ISMS for assistance. Physicians are also encouraged to fill out the complaint form on the bottom of page seven and mail it to: ISMS, Health Care Finance Department, 20 N. Michigan Ave., Chicago IL, 60602. ■

Classified Advertising

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Illinois Medicine is published every other Tuesday except the first Tuesday of January and July; ad deadlines are four weeks prior to the issue requested. Although ISMS believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify ads at its discretion. Ads will be edited to conform to Illinois Medicine style.

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Court rules

(Continued from page 1)

dures to ensure that current medical staff members receive due process if their privileges are terminated or reduced because the hospital enters into an exclusive contract or for other economic reasons.

Economic credentialing reform picked up speed in the early 1990s after lawmakers passed a resolution calling for a study of the issue. ISMS met several times with the Illinois Hospital and HealthSystems Association to hammer out a consensus bill, which eventually passed and became law in 1995. The Society's negotiating efforts were based on policies its House of Delegates approved in 1993.

"The court said it was clear that a decision to grant or take away privileges based on nonclinical reasons creates a right for the physician to a hearing," said ISMS General Counsel Saul Morse. "And the court clearly states that the relationship between the hospital and medical staff is contractual in nature and that neither side can unilaterally take action unless they do it in compliance with state statute and the bylaws."

The hospital argued that language included within the bylaws specifically states they are not a contract. The court, however, rejected this argument. "The hospital has been told by the court that it cannot, by a statement in the bylaws, override a state statute," Morse explained.

> *"This decision is the most telling example of the value of the economic credentialing reforms ISMS pushed for in 1995."*
>
> *– ISMS President Richard Geline, MD*

Following passage of the economic credentialing law, Dr. Garibaldi did receive a hearing, and the panel recommended that his privileges be grandfathered so that he is permitted to practice at the hospital.

The hospital governing board, however, rejected this recommendation. The appellate court said the trial court should hold hearings to determine whether it is fair and permissible for the hospital governing body to make the final decision when it has an economic stake in the outcome.

ISMS plans to continue monitoring the progress of this case and will keep members informed of any significant changes, Dr. Geline said. ■

Aetna

(Continued from page 1)

replace Prudential," according to Barbara Hill, the plan's chief executive officer. "We don't see either of those options changing the way we work with the medical community or the way we serve our members."

If Aetna succeeds in buying Prudential HealthCare, a division of New Jersey-based Prudential Insurance Company of America, the combined company would provide medical coverage for one in 10 Americans, enroll approximately 22.4 million members in 31 states, and have contracts with more than half – approximately 317,000 – of the nation's 550,000 practicing physicians.

"We are going to change the landscape of the whole industry," said Richard Huber, Aetna chairman and chief executive officer. Both Aetna and Prudential's members will benefit from a choice of even more physicians, he said. "In addition, Prudential HealthCare's commitment to quality, as well as the additional scale, will improve our ability to provide physicians with information that helps them get our members the care they need."

The AMA has long had a contentious relationship with Aetna, clashing frequently over the HMO's policies that prevent doctors from appealing the plan's denial of treatment or require physicians to belong to all – or none – of Aetna's plans. Both ISMS and the AMA also believe an Aetna-Prudential alliance would severely restrict patient choice in the regions of the country where they would lay claim to nearly 30 percent of the market.

"The most effective long-term solution to preventing these monopolies remains comprehensive state and national patient rights laws to protect all patients from profit-driven interference in medical decision-making, and we will redouble our efforts to get them passed," said Dr. Geline.

Although increased profitability is a driving force behind the proposed merger, Aetna also believes combining forces with Prudential will allow the company to develop a larger health information database that can be used to improve the quality of care physicians provide. The HMO collects information on how all of the physicians in its network care for their patients and will combine those data to help doctors develop treatment plans.

"That's a strong theoretical argument Aetna makes for employing a database to improve care, but trying to refine that kind of information so it's useful to physicians is very difficult," noted Douglas Sherlock, editor of Pulse, an HMO industry newsletter based in Gwynedd, Pa. Each physician serves a small universe of patients and has a different specialty, which makes it nearly impossible to create a definitive profile for treating a specific patient or illness, he noted. ■

Incentives plan

(Continued from page 1)

Ray, MD, told Blues' officials who attended the meeting of the ISMS Third Party Payment Processes Committee to listen to physicians' concerns. Physicians do not trust the motives behind the plan because it was clearly a money-saver for the Blues, Dr. Ray said.

Under the proposal outlined last October, the Blues would have paid an added $200 to a physician who performed one of the approved surgical procedures in an office setting. The proposal applies to 55 foot and ankle surgical procedures – ranging from removing a foreign body from the foot to repairing or suturing a tendon, foot or extensor – and affects podiatrists, orthopods and other physicians who perform those procedures. Physicians who performed those procedures in a hospital or surgicenter would have had $200 subtracted from their payment.

"You're trying to change the locus where procedures are done, which is out of sync with the majority of the orthopedic and podiatric community," ISMS President Richard Geline, MD, told the Blues. "By changing the payment plan, you're offering incentives to one group of physicians to move into an unsupervised, unregulated environment and asking doctors to take a big risk."

Richard Snodgrass, MD, TPPP Committee chairman, stated that he feared this incentive plan, developed initially for foot and ankle procedures, may be just the start of a policy that would be extended to entice other specialists to perform specific procedures in their offices.

Allan Korn, MD, the Blues' vice president and chief medical officer, explained the insurer's reason for the incentive program was to introduce a program in which the Blues would share half of the cost savings with physicians who choose to perform certain procedures in their office. Dr. Korn said the Blues plan is responding to physicians' concerns that falling payment levels would not adequately cover the rising cost of performing office procedures.

Dr. Korn attributed the dissension over the plan to a lack of trust between the Blues and physicians. "It was never our intent to say, 'Take these procedures out of the hospital and perform them in your offices, no matter what,' " he said. Dr. Korn noted that the procedures earmarked for incentives are ones that are frequently performed in the office. But when the proposal raised objections from providers, Blue Cross Blue Shield put implementation on hold, he said. "Before we continue with any innovative procedures, we want to understand your concerns."

The plan was initially announced in a letter sent to providers last October, but in December the Blues backed off from implementing the policy after ISMS, the Illinois Podiatric Medical Association and several other specialty groups sharply questioned its rationale. Company representatives promised to gather input from more physicians. However, the Blues drew further criticism from ISMS and the IPMA for a Dec. 16 letter sent to providers that stated that this controversial reimbursement plan would "move forward in early 1999." ISMS and others interpreted that statement to mean the Blues was breaking its earlier promise to consult the physicians who had expressed dissatisfaction with the program.

At the Jan. 6 meeting, Dr. Korn said he will soon convene a group of podiatrists and orthopods to review the list of incentive procedures. The Blues will advise the Society and the IPMA before implementing any changes, he said. ■

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WHEN IT MATTERS MOST

IES: WHAT ARE YOUR PATIENTS TAKING? (PAGE 8)

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • FEBRUARY 12 1999

Schedule change:

Illinois Medicine is now being published every three weeks (except every two weeks in May and June). Watch for your next issue March 5!

Credentialing Pursuit: Physicians are tired of playing this game

PAGE 6

FOLLOW-UP

LUNDBERG DISMISSAL THE RIGHT MOVE

ISMS applauded the American Medical Association's recent dismissal of JAMA editor George Lundberg, MD. "We support the move by the AMA – JAMA's owner – to finally take a decisive interest in the content of the product and the editor's role in shaping our professional image," said ISMS President Richard Geline, MD. Although he credited the editor with building JAMA into a respected source of medical knowledge, he said that Dr. Lundberg tested the limits of editorial freedom. On Feb. 3, the AMA and Dr. Lundberg announced they have resolved their substantive differrences.

FEDS SOUND NEW FRAUD WARNING

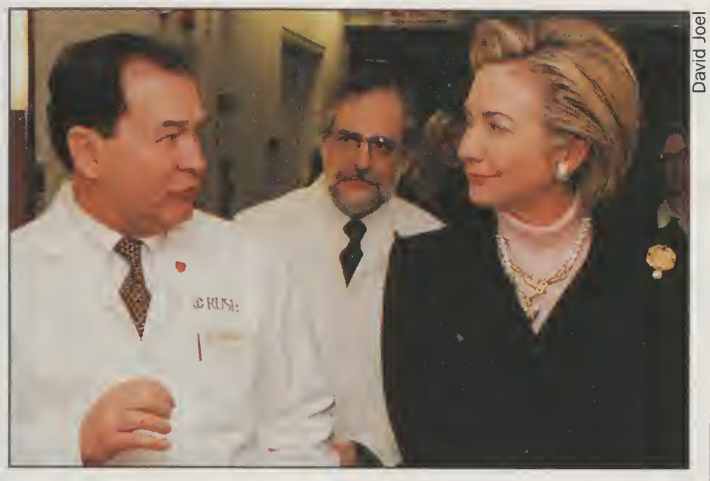
A new fraud alert warns that physicians who submit false or misleading certifications of medical need for durable medical equipment or home health care services for Medicare patients may face stiff criminal, civil and administrative penalties. The alert, issued by the federal Office of Inspector General, cautions physicians against signing a certification as a "courtesy" to a patient or service

(Continued on page 3)

30% PREMIUM INCREASE FOR FRONTIER DOCS

Frontier HealthCare's recent decision to take a $150 million fourth-quarter charge to pay off its onerous debt is merely the latest example of the medical professional liability insurance carrier's struggle to stanch its freely flowing red ink. Frontier will use $139 million of its charges to cover its massive liability insurance losses, which industry analysts

(Continued on page 3)



David Joel

First Lady Hillary Rodham Clinton tours the new epilepsy monitoring unit at Chicago's Rush-Presbyterian-St. Luke's Medical Center on Jan. 13, accompanied by Leo Henikoff, MD (far left), president and CEO of the medical center, and Andres Kanner, MD, associate director of the epilepsy unit.

AMA reduces dues: rebate out soon

Pilot program launched for Illinois as a unified state

In recognition of Illinois' unified membership status, the American Medical Association has introduced a dues-savings pilot program for 1999 in which regular members pay reduced dues of $300. This amount reflects a reduction of 19 percent in addition to the 10 percent discount already granted to members from unified states – totaling a 29 percent discount from the AMA's regular dues of $420.

"By implementing this pilot program, the AMA further recognizes the special contributions that the members of unified medical societies make to the AMA," said Arthur Traugott, MD, ISMS Board of Trustees chairman.

The dues reduction applies only to full dues-paying members. Illinois members who have already paid their 1999 dues will receive a rebate check from the AMA within the next few weeks.

The launch of the dues-savings program was the result of several months of discussion between ISMS leaders and the AMA. In a December 8, 1998, memo, AMA Board Chairman Randolph Smoak, MD, emphasized the AMA's commitment to reexamine the membership benefits for unified state societies as part of its larger review of innovative membership programs.

"The dues savings is one part of ongoing collaboration between the AMA, ISMS and county medical societies to

(Continued on page 10)

The battle for patient rights begins anew

BY PAULA KRAPF

ISMS fired the first round in the fight for patient rights legislation Feb. 3, when the Managed Care Patient Rights Act was introduced to a Legislature that has shown increasing support for HMO reform.

"The introduction of House Bill 579 continues our fight for managed care accountability and patient rights legislation, which is our No. 1 priority," said ISMS President Richard Geline, MD.

The prospects for MCPRA look good, said Rep. Carolyn Krause, (R-Mt. Prospect), who is one of HB 579's five principal sponsors, along with Reps. Gwenn Klingler (R-Springfield); Jeffrey Schoenberg (D-Wilmette); Ralph Capparelli (D-Chicago); and Sara Feigenholtz (D-Chicago).

On the day it was introduced, the bill had bipartisan support from more than 50 cosponsors. (See the ISMS web page at www.isms.org for a complete sponsor list.)

mission: MCPRA needs your support
- Call to action (insert)
- Editorial (page 4)

ISMS' goal this year is to pass a strong managed care patient rights act that can pass both houses and be signed by the governor, said Nestor Ramirez, MD, chairman of the Governmental Affairs Council. "We assumed a leadership role in crafting the details of the legislation because if we didn't, this important issue would be controlled by insurance interests that do not put patients first," he said.

MCPRA stalled in the General Assembly last year after both legislative chambers passed their own versions of the law and failed to reconcile their differences. However, the

(Continued on page 10)

Health care hotline

Attorney General's office investigates physician and patient complaints against health plans

BY PAULA KRAPF

[CHICAGO] A new hotline established by the Illinois Attorney General's office to collect complaints against health care plans was flooded with calls its first official week of operation.

The hotline registered 375 calls in the first seven days following its Jan. 26 unveiling, said Jacqueline Zydeck, chief of the attorney general's new health care bureau established in October. The hotline collects complaints for the bureau, which has begun investigating and mediating grievances about unfair and deceptive practices in the marketing and delivery of health care.

Andrew Corrigan Halpern

Clair Callan, MD (right), ISMS president-elect, and Jacqueline Zydeck, chief of the Illinois Attorney General's health care bureau, participate in a forum in Chicago to publicize the state's new health care hotline.

(Continued on page 10)

INSIDE

Court ruling sides with physicians

PAGE 3

DEPARTMENTS

Health care costs contained, but not for long

Although 1997 witnessed the slowest increase in health care expenditures in 40 years, those costs will start to soar once again as managed care organizations raise their rates to compete in a tightening marketplace, according to the 1997 National Health Expenditures report released in November by the Health Care Financing Administration.

HCFA projects that growth in public health spending will nearly double during the next decade and hit $2.1 trillion in 2007; cost per person will reach approximately $7,100.

In fact, the steep premium hikes have already begun: the federal Office of Personnel Management announced that health insurance premiums for the government's 8.7 million employees will rise by an average of 10.2 percent in 1999, the biggest increase in a decade.

Meanwhile, total health care spending amounted to $1.1 trillion in 1997, an increase of only 4.8 percent more than 1996, according to HCFA. Although physicians and hospitals generally accounted for most of those costs, both groups kept their costs in line with managed care's cutbacks during 1997.

The cost of physician services grew by only 4.4 percent in 1997, to $217 billion, and continued a trend of single-digit increases that began in 1992.

Dwindling spending rates from public funding sources such as Medicare and Medicaid also contributed to the overall slowdown in health care spending. Annual Medicare costs rose by 7.2 percent to $214.6 billion in 1997, while Medicaid spending grew by only 3.8 percent to $159.9 billion, the lowest increase since the program's inception 30 years ago.

Expenses for prescription drugs, which climbed by double-digit percentages, as well as the additional cost of home health and other services have picked up the slack, however.

Moreover, HCFA's statistics revealed that per-person spending was less than $4,000 in 1997, and for the first time since the late 1980s, out-of-pocket spending grew faster than private health insurance. Costs associated with premiums, coinsurance and copayments hit $187.6 billion in 1997, primarily influenced by HMOs that required enrollees to pay more for plan benefits.

As health care becomes costlier and possibly more difficult to procure, ISMS will be looking out for patients, said ISMS President Richard Geline, MD. "Managed care has cut costs, but at a price," he said. "The deceleration of health care costs also makes a managed care patient rights bill more necessary than ever to guard the ability of doctors to provide the level of care patients need. We'll be the ones to lead the fight." ■

New address for triplicate R_x forms

Physicians seeking triplicate prescription forms need to send their renewal or application forms to a new mailing address.

The address change is needed because the state reorganized and relocated several government departments. The prescription forms, which are used for Schedule II controlled substances, must be renewed every two years.

To obtain the forms, applicants must have an Illinois medical license, Illinois controlled substances license and federal controlled substances registration, all of which must be current and in good standing.

The new address is: Department of Human Services, Triplicate Prescription Control Program, P.O. Box 10257, Springfield, IL 62791-0257. For more information, call the Triplicate Prescription Control Program, (217) 782-1384, or contact Sue Gorman, the program's regulatory supervisor, at (312) 814-6390. ■

OMSS annual meeting slated for March 13

The ISMS Organized Medical Staff Section will hold its 14th annual meeting and educational program 9 a.m.-3 p.m., Saturday, March 13, at ISMS headquarters, 20 N. Michigan Ave., Chicago.

All ISMS members are invited to attend the educational portion of the meeting. There is no charge for registration. Presentations will address "Managing medical practice information needs for building success with managed care," "Controlling the environment in which you practice," and "Managed care and the organized medical staff."

The annual business meeting will follow immediately. It will include election of ISMS-OMSS Governing Council members and review of resolutions to be referred to the ISMS House of Delegates in April and/or the AMA-OMSS assembly in June. Only duly credentialed ISMS-OMSS representatives may submit resolutions and vote at the annual business meeting.

The deadline for resolutions to be considered at the ISMS-OMSS annual meeting is Feb. 15.

Call (800) 782-ISMS for more information and for details about registration.

mission: MCPRA

A call to action

Setting the record straight

IAHMO report distorts fiscal impact of Managed Care Patient Rights Act

BY PAULA KRAPF

The drive to pass a managed care patient rights act

Numbers in an HMO-sponsored cost analysis that claim patient rights legislation in Illinois would hike premiums by 10.2 to 12.3 percent don't add up, according to an ISMS analysis.

"The study's validity is highly questionable given the political motivations of its sponsor," said ISMS President Richard Geline, MD. The report was paid for by the Illinois Association of Health Maintenance Organizations. "This report is clearly motivated by the fact that IAHMO doesn't favor the managed care legislation that is on the table," Dr. Geline said. "In several cases the report's conclusions are based on an incorrect understanding of the legislation."

The report in question, conducted by the Barents Group, a Washington, D.C. - based consulting firm, concludes that the Managed Care Patient Rights Act would cause HMO premiums in Illinois to rise on an ongoing basis. Further, the IAHMO report states that Illinois' HMO premiums, which currently cost $4.1 billion, would increase by $421 million to $505 million.

In contrast, a sweeping patient rights act cost analysis conducted by the Congressional Budget Office last July found that comprehensive managed care patient rights legislation would lead to a one-time, total premium hike of 4 percent that would be phased in over 10 years. This is much lower than the IAHMO study – even though the CBO study examined the fiscal impact of a more expansive federal patient rights bill. That legislation includes many of the provisions in Illinois' proposal.

CBO, certainly a more unbiased source on the cost of patient rights legislation, does not project a large premium increase, particularly when compared with the benefits that would be gained when patients can choose their own doctors and have unrestricted access to the care they need, Dr. Geline said.

An ISMS analyst refutes IAHMO's analysis, which appears to be based on faulty assumptions. The report focuses on four of the act's provisions:

1. Issue: Transition of services – Health plans must allow new enrollees in HMOs the choice of continuing to receive ongoing treatment from providers outside the plan's network for at least 90 days.

IAHMO response: The IAHMO study claims health insurers won't be able to negotiate discounts with physicians and other providers who practice as part of independent practice associations and that plan members would use more expensive specialists.

ISMS response: This MCPRA provision is directed at managed care organizations, not IPAs, said Dr. Geline. "It may take longer for patients to get into the system due to the transition period, but this should have a small impact, given that most patients select an insurance plan and stay with it," he said. This would affect only a small number of patients – those with ongoing treatments – and only for a short period of time. In addition, out-of-network physicians must accept the new plan's reimbursement rates and quality assurance requirements; provide the plan with medical information about the care provided; and adhere to the plan's policies and procedures, including but not limited to referrals and obtaining preauthorization for treatment. All of these provisions are intended to ensure that this provision does not increase costs to HMOs.

2. Issue: Access to specialists – Plan members can select any primary care provider in their health plan to coordinate their care. In turn, the PCP can set up standing referrals for patients to receive care from specialists who have a referral arrangement with the PCP.

IAHMO response: IAHMO asserts that this provision means HMOs would become point-of-service plans that must offer enrollees an option to choose doctors outside the plan or be forced to bypass contracting with IPAs. According to IAHMO, this will increase costs significantly.

ISMS response: The PCP and specialty physician must have a referral arrangement. PCPs retain control for secondary referrals and are entitled to ongoing information about their patients. Dr. Geline added that the requirement that physicians have a referral arrangement was added at IPAs' insistence and should not result in a significant increase in premiums.

According to IAHMO, provisions relating to the transition of services and access to specialists would increase premium costs for IPA-model HMOs by 10 to 12 percent. The CBO, however, estimated that the net effect of similar provisions would be a one-time 0.4 percent

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premium increase across all employer-sponsored health plans over a 10-year period.

3. Issue: Quality assessment program – A health care plan must develop and implement a quality assessment and improvement strategy that meets the accreditation standards of the National Commission for Quality Assurance, American Accreditation HealthCare Commission/URAC, Joint Commission on Accreditation of Healthcare Organizations or another entity approved by the Illinois Department of Public Health.

IAHMO response: Because plans are supposed to have quality assurance procedures in place, this provision should result in only limited expansion of existing procedures.

ISMS response: The Society agrees that measures to include a quality assessment program in a patient rights law should move forward.

4. Issue: Utilization review program registration – Utilization review programs must be filed with IDPH and use URAC standards. No managed care entity or other insurer will be required to obtain additional accreditation, but they must meet URAC, so there is minor cost associated with the requirement.

IAHMO response: Because plans already have utilization review procedures in place, this provision should result in only limited expansion of existing procedures and should not cost a great deal.

ISMS response: The Society agrees that good utilization review procedures are vital. "Quality assessment and utilization review are vital provisions because we need ongoing monitors for quality of care, and the cost is both minimal and justified," said Dr. Geline. "IAHMO appears to agree with us on these issues."

MCPRA proposals expired in the General Assembly last year, after both chambers of the Legislature passed their own versions of the bill and failed to reconcile their differences. Legislation will be reintroduced during the spring 1999 legislative session, and ISMS' top priority will be "seeing MCPRA become law," said Dr. Geline. "It is our understanding of MCPRA that it will not cost a great deal to implement, as has been asserted by MCPRA opponents," he added. "This position has been supported by many analyses, most recently the CBO study." ■

Fraud warning

(Continued from page 1)

provider when they have not undertaken a determination of medical necessity; knowingly or recklessly signing a false or misleading certification; or receiving patient referrals, supplies, equipment, cash, reduced rent or other compensation in exchange for signing the certification.

Physicians will not be held personally liable for a single false certification resulting from negligence, mistakes or inadvertence. However, those who intentionally make false or misleading certifications, even if they do not receive any financial or other benefit from providers and suppliers, can be hit with penalties including criminal prosecution, fines as high as $10,000 per false claim plus treble damages, expulsion from participation in federal health care programs, or loss of license or disciplinary actions by state regulatory agencies.

Lax completion and review of certifications allow unscrupulous suppliers and home health care providers to take advantage of physicians. The OIG wants physicians to report to it any suspicious solicitations for authorizations or certification completions. For more information, access "On Your Behalf" in the News & Events category of the ISMS web site: www.isms.org.

Premium increase

(Continued from page 1)

attribute to its underpriced premiums.

The carrier also ended 1998 on a sour note after racking up a $25 million loss. The new year brings less than good cheer for policyholders: Frontier informed Illinois physicians last fall that its 1999 base rates for liability insurance will climb by nearly 30 percent, a move industry analysts attributed to Frontier's practice of lowballing premiums. In light of those events, the national rating agency A.M. Best Co. recently assigned the company a negative rating outlook, although it affirmed Frontier's A- "excellent" rating.

"What this case illustrates is that many malpractice insurance carriers keep repeating the same mistakes," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "When they enter a new market, they use marketing gimmicks such as unrealistically low predatory pricing. Then, to recover, they have to adopt substantial rate increases or abandon the market completely. ISMIE, on the other hand, has had a successful track record for more than 21 years."

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Supreme Court reverses ruling on mental illness in suicide case

BY PAULA KRAPF

The Illinois Supreme Court last month overturned an appellate court decision that prohibited a family physician from using a "contributory negligence" defense for a medical malpractice lawsuit that stemmed from a patient's suicide.

Daniel Shin, MD, had been sued by the mother of his late patient, Kathryn Hobart, who had committed suicide by ingesting a lethal dose of an antidepressant that had been prescribed to her both by Dr. Shin and her psychiatrist. The patient's family contended that Dr. Shin failed to consult with the psychiatrist before writing the prescription and provided the patient with access to enough antidepressants to commit suicide.

Testimony from the Hobart vs. Shin trial indicated that the patient had been depressed but had denied feeling suicidal. Evidence indicated that she received appropriate medical treatment from her psychiatrist and Dr. Shin, including the antidepressant prescription, according to ISMS General Counsel Saul Morse.

After Hobart was released from the hospital, her psychiatrist and Dr. Shin observed that she was happy and discussing future plans. She asked for a larger prescription refill to avoid trips to the pharmacy, then checked into a motel using a fictitious name and took a lethal dose of the medication.

By reversing the appellate court's 1997 opinion, the Supreme Court concurred with the arguments made in an amicus brief the Illinois Psychiatric Society and ISMS submitted to that court last June, observed Morse.

ISMS President Richard Geline, MD, hailed the ruling. "The high court acknowledged that physicians need discretion to provide good medical care when treating patients; the appellate court's decision, if left standing, might have deterred physicians from providing that care and thus harmed our patients," he said.

ISMS, in conjunction with the IPS, supported the contributory negligence legal theory, which says patients can be responsible for some or all of their injuries. A jury determines the degree to which plaintiffs contribute to their injuries, and they cannot recover any damages if they are deemed to be more than 50 percent responsible.

In 1995, a Cook County Circuit Court jury sided with Dr. Shin, but following an appeal from the plaintiff, the appellate court ruled that "mentally ill" individuals cannot be responsible for their conduct. "That decision placed physicians in the untenable position of guaranteeing all the results for mentally ill patients," Morse said.

Drawing from the amicus brief filed by ISMS and IPS, the defense argued before the high court that patients who have a mental illness can still make decisions and be held responsible for their actions.

"If the evidence discloses that such patients are completely devoid of reason as a result of their mental illness and unable to understand what they are doing, then they are incapable of being contributorily negligent," Morse added. "However, only in those cases in which the evidence permits no other rational conclusion would a plaintiff be entitled to have this issue determined as a matter of law."

IPS President Sidney Weissman, MD, added that the Supreme Court's opinion took into account the chilling effect the appellate court's ruling could have had on the physician-patient relationship.

"The court stated that no health care provider would want to risk the liability exposure in treating such a patient, and thus, suicidal persons would be denied necessary treatment," he said. ■

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EDITORIAL

Mission MCPRA: A call to action

Illinois stands on the launching pad of a mission to adopt a managed care patient rights act. There's great potential for the mission to be a success. George Ryan, Illinois' new governor, has a long history of working with physicians on issues that will improve the quality and delivery of health care. He has vowed to help pass and sign a law to remove the roadblocks that health plans throw in the path of good medicine.

MCPRA's chances of being passed also are bolstered by a public outcry to end health insurance plans' abuses; that outcry has reached a high pitch legislators will be hard-pressed to ignore.

The next few months will be a pivotal time as the Legislature grapples with proposals and counterproposals from opposing forces pulling between good patient care and profit motivations. ISMS has set the passage of a patient rights bill as a top priority. The Society is poised to exert its leadership in Springfield to shape and pass legislation that will give citizens a voice in achieving greater access to treatment.

What steps must all Illinois physicians take to support the mission? First, they must enlist in the cause. Politicians are influenced by big numbers, and an organization that represents a strong voting bloc will surely have an easier time capturing their attention. Physicians cannot afford to look weak at this crucial juncture. To encourage membership growth, the AMA has agreed to reduce dues for Illinois physicians as a benefit in return for ISMS's unified membership status.

Second, physicians must march together, cooperatively working out their differences to present a united front for change.

Finally, and probably most important, physicians must take part in the process. Physicians should immediately contact their representatives in Springfield to explain – with details and examples – what it is like to toil daily to treat patients in an atmosphere in which the managed care system is unchecked.

In the coming weeks, ISMS members can expect to receive legislative alerts calling them to act swiftly to lobby House and Senate members in the General Assembly prior to key votes. With a fax, phone call or quick e-mail, physicians must respond to those calls as a demonstration of strength and support. Read the insert between pages two and three in this issue of Illinois Medicine to learn more about the questions expected to be addressed in the patient rights debate.

It is guaranteed that there will be forces representing the profit-motivated insurance interests working against these important changes. The squeaky wheel does get the grease – in this case the legislators' attention. Physicians must show the General Assembly that they want the government to enact a law that protects their patients.

PRESIDENT'S LETTER

Let's work together to solve the problem of late payments

Richard A. Geline, MD

The inability – or unwillingness – of insurers to pay physicians on a timely basis is more than a doctors' problem.

Getting paid for completed work is a growing problem doctors face in dealing with managed care. A colleague told me recently that his group is owed more than $500,000 by a single managed care organization.

We hear reports of payments for properly prepared claims delayed by more than 100 days. Perhaps the most prominent case involved Oxford Health Plans, which, according to the New York Times in 1997, delayed for at least three months payments of more than $600 million owed to doctors and hospitals.

Under these circumstances, physicians and hospitals are essentially providing an unapproved interest-free loan to the managed care organization. Perhaps it should be termed a "gift" rather than a loan. Princeton health care economist Uwe Reinhardt found that some health insurance carriers can earn up to $400,000 per day in interest on withheld funds.

The inability – or unwillingness – of insurers to pay physicians on a timely basis is more than a doctors' problem. Some physician groups with large amounts of outstanding bills may need to withdraw from certain managed care organizations, unavoidably disrupting existing patient relationships and diminishing patient access to care. Some patients may be billed directly and unexpectedly when the bills remain unpaid, leading to confusion and possibly a weakening of doctor-patient trust.

Physicians have employed several strategies to recover delayed payments or avoid them in the first place. Some suggestions:

• Identify all information necessary for a clean claim. A claim is usually considered "clean" if the invoice: identifies the professional providing treatment, including a matching provider number; identifies the patient; includes a diagnosis in ICD9 format; lists the date of service; lists the place of service; includes an itemized record of services provided in the current CPT format, with billing shown by CPT code.

• Negotiate a stronger contract. What does your contract say about late payments? Is there a set time by which the plan must pay your claims? Is there a penalty if payment is not received within a certain time frame? These questions should be answered clearly by contractual language.

• Document claims activities. If claims are consistently being returned for more information, you may need to assign a special staff member to the task or hire a practice management firm or consultant to determine whether there is a pattern that can be corrected internally.

• Update your billing system. The right computer software can have a tremendous impact on both getting payment faster and tracking claims accurately. Electronic filing of claims has many advantages. One study found that physicians who submitted claims electronically had 21 percent fewer claims returned than those who submitted them on paper. Electronic filing also will allow you to better document patterns of late payment.

• Write letters to payers. Identify outstanding claims and include documentation. Request immediate payment. The old adage "the squeaky wheel gets the grease" certainly applies. Tell ISMS, too. Our Health Care Finance Department will help you contact late payers and work through the bureaucracy to get you what you are owed.

• Report the consistently delinquent payer. If you have documented a pattern of consistently late payments, report the carrier to the Illinois Department of Insurance.

In response to action taken at our 1998 House of Delegates Annual Meeting, the ISMS Governmental Affairs Council is working on legislation to ensure timely payments. Help us reach that goal. Share your experiences with me (geline@isms.org) so I can help lawmakers understand the extent of the problem. The result can be well worth the time invested.

GUEST EDITORIAL

Rules changing on road to long-term care

By A.S. Maurer, MD

Many physicians are wondering why some of their patients have seen changes in admission and other policies at skilled nursing facilities. The straightforward answer is that the Balanced Budget Act of 1997 provided many long-term care facilities with reimbursement under the prospective payment system, which is the nursing home equivalent of a hospital's diagnosis-related groups. The PPS has initiated changes in the way patients are evaluated for admission, the care they receive and the method of payment for services.

Although the new system ultimately intends to enhance quality of care while improving the utilization of resources for hundreds of thousands of long-term care residents, the transition has been turbulent – the same way it was for hospitals. Just as there was fallout on physicians in hospitals then, there will be new expectations on physicians in SNFs now to adjust how they provide some aspects of care.

For example, physicians' cooperation will be sought to reduce ambulance transfers and perform some procedures in SNFs that have, up to now, been done in hospitals. Gone are the days when a physician in a SNF could proclaim, "Send the patient to the hospital for X-rays!" Today's SNF physician instead orders, "Bring in the portable X-ray machine!"

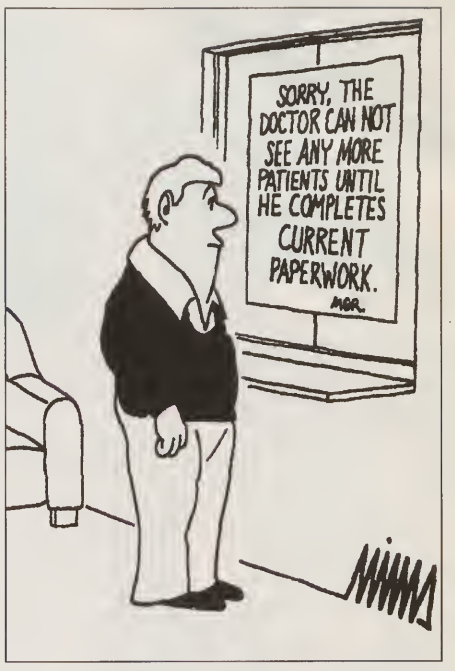
Driving that issue, the Health Care Financing Administration recently ruled that only the following procedures are eligible to be billed by a hospital: magnetic resonance imaging; CT scans; cardiac catheterization; ambulatory surgery involving the use of an operating room; emergency services; radiation therapy; angiography; and lymphatic and venous procedures. All other nonemergency Medicare-billed services are the responsibility of the SNF, including the payment for patient ambulance transfer.

Like it or not, long-term care facilities will be required to craft a new set of rules for physicians if they are to continue to provide quality service to patients and maintain financial viability. One modification will require that physicians complete diagnostic processes while their patients are in the hospital, because long-term care facilities can't afford to send their residents back and forth to the hospital for tests. And because facilities will not be able to afford to order a whole new round of testing midstream, physicians will also have to develop solid treatment plans before admitting patients to a nursing facility.

At the very least, turning to resource utilization groups will help physicians decide whether it is time for a patient to move along the continuum of care. RUGs are the reimbursement categories that determine up front what a facility will receive for all services rendered. Today they are the basis for many of the decisions made in a long-term care facility.

There is no doubt that the PPS transition phase is increasing the stress levels of long-term care staff. It might very well do the same for physicians. SNFs are trying to analyze their products and services more closely, keep a handle on therapy schedules and maintain their ability to render high-quality care. Long-term care nursing staffs are also mandated to assess each resident's care and electronically submit reports regularly to the federal government. This procedure allows the government to evaluate and compare quality among all facilities.

There is concern on the part of long-term care facilities that this might strain relationships with their attending physicians. The fact is, however, that the "bottom line" has simply shifted; administrators and nursing staffs are trying to regain their footing, and are



eager to work with physicians and make the PPS system work. For this to happen, both long-term care staffs and physicians must agree that PPS changes can't compromise patient care, nor can they erode the doctor-staff relationship. ■

A.S. Maurer, MD, is an associate professor of clinical family medicine at the University of Illinois College of Medicine at Peoria. Dr. Maurer is a family practitioner who has worked extensively in the field of geriatrics and long-term care. He holds a long-term care administrator's license.

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BY PA

The object of the game sounds simple enough – insurance providers credential medical practitioners to verify that they have the requisite training, board certification and insurance coverage. It begins with the mailing of verification forms – still sounds easy. But a single roll of the dice can send contestants back to square one, penalize them with a pile of paperwork and possibly postpone patient care.

"Credentialing is a pain in the neck," declared Steven Malkin, MD, an internal medicine specialist for Medical Care Group in Skokie. "Initial credentialing for a physician new to a program can take six months to one year – and it doesn't end there. We have to be recredentialed with the same insurer every two years," he said. "The process is constant. I get bombarded monthly with identical forms from 10 different HMOs."

In addition to paperwork burdens, physician offices must constantly endure disruptions by site visits, in which surveyors from the health plan analyze the day-to-day aspects of the practice by examining patient charts and other documents, he added.

Another problem is that the credentialing process often turns patients into unwitting victims, because established physicians may be barred from seeing longtime patients without first being credentialed by the patients' new health plans, added Elizabeth LeClair, the office manager for Medical Arts Family Physicians in Gurnee. This three-physician practice grapples with 72 insurance carriers and uses two IPAs to handle its multiple insurance contracts.

"We lose continuity of care for several months to a year or more, which frustrates patients and physicians," LeClair said. "Patients don't understand when we explain, 'You can't see the doctor you want to see, but you can see another doctor in our group.' Patients know their doctor is on our staff, but I have to tell them that the insurance company doesn't know that yet," she added. In the meantime, practices must absorb the cost of a provider who isn't generating sufficient income.

A substantial contributor to credentialing time lags is the paper chase, according to Gina Dalby, coordinator for the Lake Forest Managed Care Association, a physician-hospital organization that handles credentialing for its members, which include Medical Arts Family Physicians.

"I'm a fan of the theory behind credentialing: ensuring that providers are in good standing," she said. "But many snags slow down the system. When a primary source such as a training hospital doesn't verify information for a month, that creates the risk that the expiration date will pass, and we'll have to start all over again."

The primary-source verification stage is rife with snags, agreed Gerald Silverstein, MD, senior vice president and chief medical officer of NYL-Care Health Plans in Oak Brook. The recredentialing cycle – sending out paperwork, receiving responses and approvals from sources – should take only three months, he said, although it can take much longer.

Physicians, too, slow up the process at times,

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Dr. Silverstein observed. "Quite often, we have to send physicians two or three registered letters and even drop some from our plan because they didn't complete their paperwork. They may think they already filled out the forms because they had to do so for several other plans."

Physicians caught in the game of credentialing pursuit say they often feel like pieces in a game of Sorry – just as likely to fall backwards or get stuck in one place as they are to move forward.

One way to speed up the trek to the finish line is to establish a common set of rules for all players. That will be a formidable task because the trick to getting a single credentialing system is convincing all insurers to dismantle their current processes and accept a single replacement, observed Richard Snodgrass, MD, chairman of the ISMS Third Party Payment Processes Committee. No plan is required to use another system, and most continue to use their own arrangement, he pointed out.

ISMS' House of Delegates voted at its Annual Meeting last spring to monitor the American Medical Accreditation Program, a pilot project being developed by the American Medical Association. AMAP establishes a single national credentialing standard that health plans can choose to purchase. Plans also may continue to require submission of their own form.

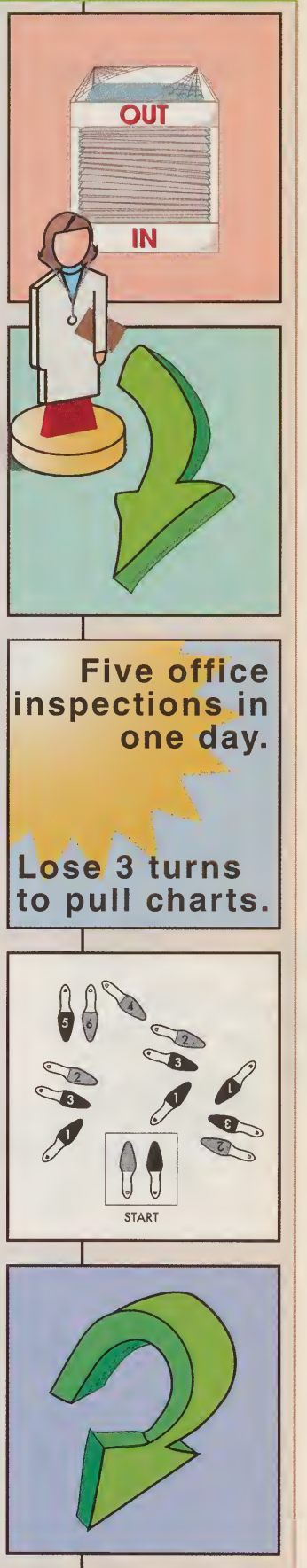
The TPPP Committee is exploring the AMAP option, Dr. Snodgrass said, assessing its cost and, more important, awaiting word on whether insurers are likely to subscribe to it. AMAP is up and running in a few states, and has hit some financial and participation bumps in start-up projects in New Jersey, Washington, D.C., Montana and Idaho. It has accredited about 261 physicians and rejected 109. Contracts are pending in Hawaii, Utah, Massachusetts and Connecticut. New York, California and Florida will go online in 1999, according to Richard Hughes, AMA director of AMAP development and purchaser relations.

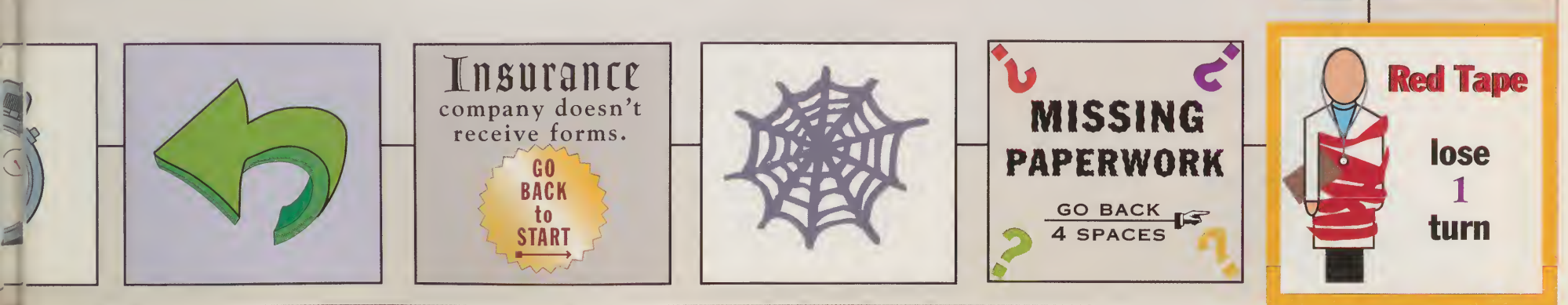
Unified credentialing proponents say it would eradicate delays and red tape that paralyze physicians, confirmed Jane Stein, executive director for the Lake County Medical Society. Several society members have brought their credentialing concerns to Stein's attention.

In fact, until an alternative reaches Illinois, several county medical societies are looking at establishing their own credentialing systems. The Chicago Medical Society is one, said Dr. Malkin.

Meanwhile, the crusade continues for a sole credentialing system that all parties will embrace. A promising Florida law that goes into effect in June will require each physician to submit basic credentialing information to a single entity, which will provide those data to any organization wanting to credential that doctor. The organization can request additional information, but must obtain the basic data from the entity the physician designates.

"Florida's law is very appealing," says Dr. Snodgrass. "It goes a long way toward eliminating the hassle that forces us to jump through hoops in order to be credentialed." ■





Coming soon: Direct-to-consumer drug advertising – Hype or help?

ISMIE Update

Herbal remedies: What are your patients taking?

BY JAY FERRARI

From the humble willow-tree origins of aspirin to the rare remedies emerging from the heart of the rain forest, nature and medicine are inexorably linked. And even though the laboratory has long been the incubator for contemporary cures, more people are realizing the effectiveness of supplements coming directly from the plant kingdom.

Julia Anderson-Miller

The window box or backyard garden probably won't replace the corner pharmacy outright, but the discovery, and in many cases the rediscovery, of the positive effects of herbal remedies and therapies are more than a here-today gone-tomorrow fad. Herbal medicine has become a significant component of mainstream medicine that physicians increasingly acknowledge.

For physicians, this trend is accompanied by the expanded task of keeping up with what medications their patients are using, whether prescriptive or alternative. Valerian, St. John's wort, ginseng, gingko biloba, saw palmetto, even humble garlic, are all becoming extremely popular, having worked their way even into the lineups of popular vitamin producers such as One-A-Day and General Nutrition Center (GNC).

The increased use of herbs among the general public demands extra savvy from physicians. Being remiss in the knowledge of how herbs work, and who is taking them, can have hazardous medical consequences for patients as well as legal complications for physicians. Articles in national media including Time magazine, The Wall Street Journal and the New York Times have addressed the double-edged potential of herbal remedies – appreciated by patients for their healing, yet often unproven in their effectiveness. As physicians witness firsthand the surge in alternative medication use, their response is frequently one of careful regard and caution.

Albert Ray, MD, a Joliet anesthesiologist, defines alternative medicine as something not generally taught in medical school. "There are without a doubt some valid elements to alternative medicine," said Dr. Ray. "Most of us believe in the effectiveness of some herbal remedies. I grew up in the South and still remember sassafras tea and mustard plasters."

But Dr. Ray added that physicians must urge their patients to use common sense when taking any supplement, be it over the counter, herbal or alternative. Dr. Ray cited the new Physicians' Desk Reference devoted to herbal and alternative remedies, which demonstrates an increased need for immediate, accessible information on the subject. "Go into this area carefully, and as informed as possible. Constantly admonish patients to tell you everything [about their alternative remedy use]." The major fear for physicians is that patients will experience adverse interactions, Dr. Ray said.

A raft of recent newspaper and magazine articles urges patients to use common sense and to communicate with their physicians when self-medicating with herbal remedies. But, ultimately, learning what their patients are using remains physicians' responsibility, said Jerry Barenbaum, an attorney with Hinshaw & Culbertson in Rockford.

Questions about patient usage of herbal or dietary supplements and remedies should be part of the basic medical history physicians collect and record from patients, he said. Physicians can therefore make decisions in an informed light and, if necessary, suggest that a patient discontinue his or her self-administered herbal regimen, Barenbaum added.

Herbert Sohn, MD, a urologist at the University of Chicago/Weiss Memorial Hospital, has set up in his practice a system of inquiry that encourages patients to tell him specifics about all supplemental drugs they use, whether classified natural, herbal or alternative. The significance becomes especially important prior to surgical procedures, he said.

"I have to make sure my patients are taking nothing that might cause adverse reactions in surgery," Dr. Sohn explained. "Blood thinners could exacerbate bleeding or cause drops in blood pressure, for example."

The importance of this knowledge also applies to legal implications. A patient on a regular self-medication schedule who neglects to volunteer any information about the herbs he or she uses is putting the physician in serious legal jeopardy. A recent news story publicized the case of a patient who experienced a critical reaction during surgery when valerian in his system interacted with the medications administered in the procedure. The patient recovered physically, but legal ramifications to the physicians involved in the case are still unfolding.

Minimizing the chance of patients' suffering adverse interactions requires simple steadfastness. Experts advise physicians to ask patients well in advance of treatments or surgery if they are taking regular herbal supplements and to continue to ask them during all follow-up visits. Also, check again the day of the treatment.

Regarding some physicians' reluctance to accept the growing use of herbal medicines overall, Dr. Sohn suggests that physicians should "never just toss out the potential validity of an herbal medicine. Often, they are the medicines prescribed a few years later, after they are studied and approved."

Similarly, Dr. Ray added that just because there are possible concerns, "you don't throw the baby out with the bathwater. Those concerns are our job to deal with." ■

MALPRACTICE ROUNDUP

Hospital ordered to pay for fatal delayed delivery

A Detroit jury found for a plaintiff who claimed hospital personnel did not deliver her baby quickly enough. According to a synopsis of Townsend v. Mercy Hospital in the Nov. 9, 1998, issue of the National Law Journal, the woman was brought to the hospital by ambulance at the onset of delivery. Although the medical staff was informed that the expectant mother's condition was an obstetrical emergency, the plaintiff claims that staff members were "not ready for her." The delivery was delayed, and the child was born without vital signs. Despite being resuscitated, the child died seven months later. The jury ordered the hospital to pay the woman more than $7 million.

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Patient rights

(Continued from page 1)

dawning of new leadership in Illinois, combined with a political climate increasingly frustrated with health plans' abuses, is generating great expectations that 1999 will be the year Illinois adopts MCPRA.

House Speaker Michael Madigan, for one, has pledged to push for managed care reforms during this spring session. The Senate is also expected to jump on the patient rights bandwagon and introduce a bill similar to HB 579 within the next 10 days.

A second ISMS-supported MCPRA bill is expected to be introduced soon in the House by Rep. Mary Flowers (D-Chicago) and is similar to a bill that she successfully steered through the House last year, but that failed in the Senate.

Key MCPRA provisions in HB 579 forbid gag rules that prevent physicians from discussing a full range of treatment options with their patients. They further allow patients to choose their doctors; compel plans to provide transitional care for patients when their doctor leaves the network; use the prudent layperson standard for providing emergency care; require utilization review programs to demonstrate compliance with URAC or other accepted standards; develop an external review process for patients dissatisfied with their plan's complaint resolution; and obligate health plans to establish complaint-handling procedures and report the outcomes to the Illinois Department of Public Health.

In addition, ISMS' Governmental Affairs Council has reviewed several other legislative initiatives and will recommend their support to the ISMS Board of Trustees. Prospective bills for the spring 1999 legislative session would:

- Prohibit denial/delay of payment from insurers.
- Allow physicians to choose which parts of an insurance company's plan to participate.
- Define and restrict the corporate practice of medicine.
- Prohibit restrictive covenants as part of a physician's practice agreement.
- Abolish absolute immunity for hospital peer review.
- License certified registered nurse anesthetists.
- Amend the Medical Practice Act to define surgery.
- Amend the Illinois Vehicle Code to require that helmets be worn by all bicycle operators and passengers under age 16 and all motorcycle passengers under 16. ■

AMA dues

(Continued from page 1)

ensure that the concerns of members, particularly in unified states, are being addressed," noted Janis Orlowski, MD, ISMS secretary-treasurer. New AMA initiatives toward this goal are already under way. One example is the AMA's challenging of the Aetna-Prudential merger to protect patients and physicians from the harmful effects of insurance market concentration.

The pilot program will be evaluated at the AMA's Annual Meeting in June. ■

Hotline

(Continued from page 1)

Unresolved allegations may be assigned to an attorney, who can prosecute the case under the Illinois Consumer Fraud Act, Zydeck added. The bureau was established in response to the increasing number of questions and complaints about health care and managed care organizations.

The hotline accepts calls from physicians and consumers seeking to lodge complaints, ask questions or request assistance in resolving a problem. Complaints commonly reported to the hotline involve denials – of emergency or hospital care or coverage, of access to specialists, and of payment after care has been approved and provided; complaints about difficulty with the grievance or appeal process have also been made, Zydeck said.

Physicians regularly encounter problems that would be appropriate to report to the hotline, noted Clair Callan, MD, ISMS president-elect, at a panel discussion to help publicize the hotline held Jan. 28 at Chicago's Ravenswood Hospital.

As an example, Dr. Callan cited a physician group that signed a contract with an HMO and encouraged its patients to join that plan; the HMO later dropped 19 of the physician group's 48 specialists from the roster in a money-saving measure. After securing more time for its patients to switch plans, the group terminated its relationship with the HMO.

Another physician group reports that a single managed care organization owes it more than $500,000 in overdue payments for patient care; those physicians fear they can't afford to continue treating patients who belong to that plan.

The panel also included Dena Mottola, project director for the Campaign for Better Health Care, a consumer group; and Kaveh Safavi, MD, vice president of medical affairs for United HealthCare of Illinois, representing health plans.

Dr. Callan lauded the attorney general's office for its hotline initiative, and added that the state Legislature must pass a comprehensive reform law to prevent problems before they occur.

To heighten awareness of the hotline, the attorney general is holding a series of public statewide forums, with the help of ISMS.

Upcoming hotline forums are scheduled as follows: 3 p.m., Feb. 24, at Winfield's Central DuPage Hospital; and 6 p.m., March 10, at Hinsdale Hospital. Additional meetings will be scheduled throughout the state.

The toll-free hotline number is (877) 305-5145. ■

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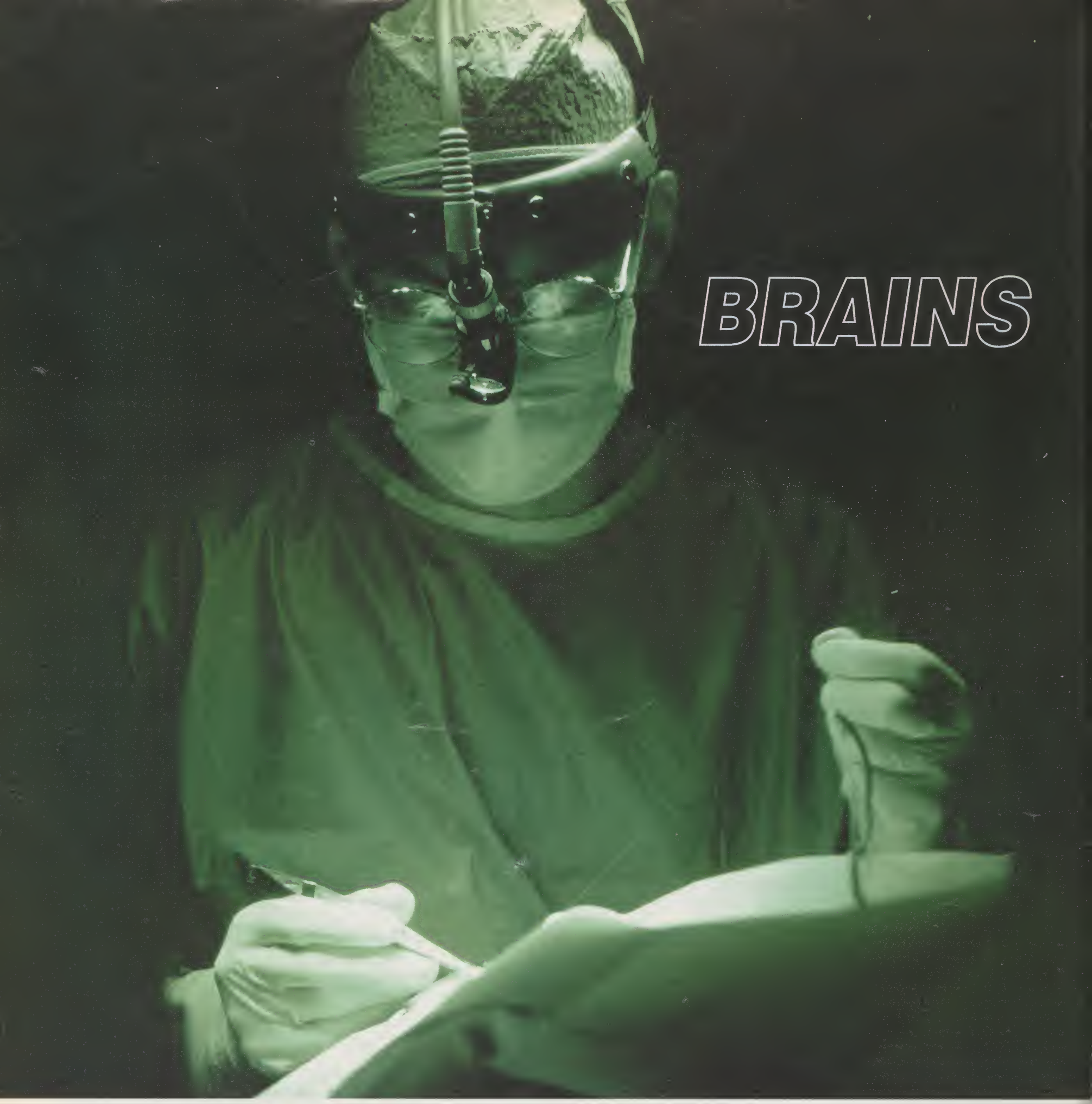

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Illinois Medicine

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Direct-to-consumer drug ads: Hype or help?

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Who are Illinois' patient rights All-Stars?

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State of the State

Governor to assess state health agencies

BY PAULA KRAPF

Three of the state's health-related departments, Human Services, Public Health and Public Aid, will be scrutinized under the microscope of Gov. George Ryan's administration as part of a large-scale appraisal he is launching to determine if the public is well-served by all of the state's agencies.

That pledge was one of many health care themes the governor touched on during his Fiscal Year 2000 Budget and State of the State address to the 91st General Assembly Feb. 17. Lt. Gov. Corinne Wood will spearhead the Performance Review Project, which will evaluate all the agencies' programs, initiatives, laws and policies and then develop a multi-year strategic plan to guide future operations.

Ryan reiterated one of his top campaign promises from last fall – his desire to pass a strong patient rights bill. "The waters of managed care reform are troubled, but they can be calmed," he said. "I'm willing to do whatever I can to help craft a solution."

The Public Aid portion of the budget is in good shape and ensures that physicians will continue to be paid in a timely fashion, according to an ISMS analyst. The suggested IDPA allocation of $6.38 billion rep-

(Continued on page 14)

INSIDE

Aaaaaand they're off...

Patient rights bills are out of the gate BY PAULA KRAPF

mission: HCPRA

With the Illinois House deadline having passed to drop bills into the legislative hopper this session, the lineup of bills that propose comprehensive patient rights reform has taken shape.

A leading contender is an ISMS-initiated H.B. 579, introduced Feb. 3, which hails nearly 60 Democratic and Republican co-sponsors. An identical S.B. 579 was introduced in the Senate days later. The bills are modeled after legislation that was passed last year by the Senate but never reached the House for ratification.

A second comprehensive patient rights bill was introduced this session by Rep. Mary Flowers (D-Chicago). H.B. 626 essentially is a repeat of a bill that passed the House last year but failed to advance in the Senate.

The ISMS and Flowers bills have many features in common, such as provisions to eliminate preauthorization for emergency room access, ban gag clauses, increase access to specialists and provide expedited channels to handle patients' complaints.

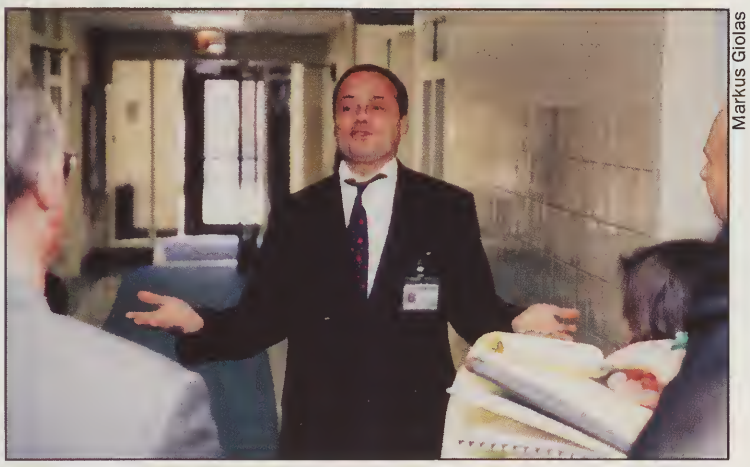
(Continued on page 18)

PATIENT RIGHTS SCORECARD

The chart below summarizes the lineup of comprehensive patient rights bills to be considered in this session of the General Assembly.

H.B. 579 S.B. 579	Features of this ISMS-initiated bill include: gag-clause ban, increased access to specialists, emergency room access without preauthorization, utilization review by national standards and a ban on hold harmless clauses	Support*
H.B. 626 S.B. 626	Introduced by Rep. Mary Flowers (D-Chicago), this bill has many features similar to the ISMS 579s, but also includes the right for consumers to sue their managed care plans, a measure some observers say will make it tough to pass.	Support*
S.B. 332 H.B. 1277	A Managed Care Reform Act supported by the insurance industry.	Oppose*

*** ISMS Position**



Markus Giolas

Medical research laboratories at the University of Illinois at Chicago College of Medicine are deteriorating, Markus Kruesi, MD, director of UIC's Institute for Juvenile Research, explains during a recent tour of the facility. The state is being asked to help fund a new $100 million research center.

UIC asks state to fund new medical facility

BY PAULA KRAPF

[CHICAGO] When the aging structures that house the University of Illinois at Chicago College of Medicine were built more than 60 years ago, the world of computers, CAT scans, MRIs, and minimally invasive procedures were more the realm of fiction writers than physicians.

But today's high-tech world makes these medical advances a routine piece of the curriculum for current UIC students. The problem is that the buildings' rundown and outmoded conditions make them unfit for training future physicians, Jeffrey Gindorf, MD, chairman of the University of Illinois Board of Trustees, told an Illinois Senate Appropriations Committee during a three-hour hearing Feb. 10 at UIC's campus.

"The electrical system is not adequate to run the equipment needed for research; there is no conduit to handle computer wiring; and the heating, ventilation and air-conditioning systems are outdated, frequently ruining experiments," he said.

S.B. 20, introduced Jan. 14 by Appropriations Committee

(Continued on page 14)

Untying an unfair contract practice

Aetna sparks antitrust accusations, proposed legislation. BY JEFF BLACK

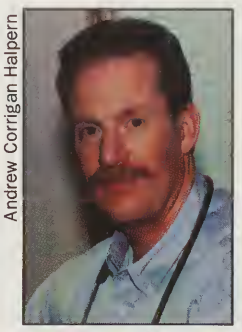
Like a mudslide inexorably determined to destroy the landscape around it, the managed care industry – with Aetna U.S. Healthcare as its bellwether – continues its assault, according to its critics, on the rights of both physicians and patients nationwide.

Now organized medicine, including ISMS, is taking on one of the more vilified business practices. The Society has helped craft legislation amending the Illinois Insurance Code to ban carriers doing business in Illinois from including egregious "all-products" clauses in their physician contracts.

Essentially, this clause requires physicians to agree, as a condition of participating in any of a health plan's products, to participate in all of them – present or future.

ISMS-backed legislation makes it "unreasonable restraint and unfair practice" for an insurer to require a health care provider to participate in all of its health care or managed care plans in order to participate in one or more of its plans.

Richard Geline, MD, ISMS president, said he is "very hopeful" about the ultimate fate of the legislation. "This kind of clause forces physicians into plans they may not find in the best interest of their patients and their practice," he said. "Some plans, for example, place unacceptable restraints on physicians, such as limiting their ability to communicate clinical and other relevant information to their patients," Dr. Geline explained. Or, some plans require physicians to take new plan enrollees, even if their practice is already full, he said. "This could lead to less time for existing patients."



Andrew Corrigan Halpern

Tom Morris, DO

Several years ago, Tom Morris, DO, a family practitioner in Burr Ridge, faced an all-or-nothing situation with a managed care organization. As a result he did something many considered drastic: he basically stopped seeing HMO patients altogether.

"I didn't like what they were doing," Dr. Morris explained. "It seemed subversive. Almost un-American. As far as I was concerned, it was restraint,

(Continued on page 17)

Motives questioned in deselection

CONTRACT CLAUSE:
What physicians should know about their rights when terminated.

BY PAULA KRAPF

When Southern Illinois University Physicians & Surgeons agreed last May to contract with PersonalCare Insurance of Illinois, the 150-member group medical practice in Springfield believed it had made a sound business decision. The Champaign-based HMO was one of the preferred providers for state employees, and by the time the health plan's enrollment period ended last June, about 500 SIU employees had signed up with PersonalCare.

But just a few months after teaming up, the relationship soured when the HMO cut 19 of SIU's 48 specialists from its roster. After unsuccessfully lobbying PersonalCare to include all of the organization's specialists on its plan, SIU Physicians & Surgeons terminated the agreement, according to its CEO, David Tkach.

The timing of PersonalCare's deselection is particularly suspect, Tkach said. He believes its full physician force was signed on as bait to entice customers and then, to save money, some of them were dropped after the June enrollment period closed.

Normally, that would have meant patients signed up believing those physicians were available to them, and they would have to wait until the following June to switch insurance carriers if they were unhappy with the limited choices.

That did not happen in this case, however, because before terminating the contract, the physician group ensured that its patients were allowed to choose between a new primary care provider or a new insurance carrier. "They were given until Feb. 1 to decide," Tkach explained.

A similar deselection situation occurred at a Springfield-based ophthalmology practice, Prairie Eye Center. In July, PersonalCare deselected the center's four ophthalmologists and four optometrists, giving the eye care practice's 197 patients enrolled in that HMO 90 days to find new physicians. An appeal to the Illinois Department of Central Management Services, which oversees health care benefits for state employees, extended that 90-day period by two months.

> *"If you narrow your network, you can lower your expenses."*
>
> *– Barry Schwartz, MD*
> *Medical Director*
> *PersonalCare Insurance of Illinois*

PersonalCare's corporate medical director, Barry Schwartz, MD, defended the company's action as a matter of economic necessity. "Costs were out of control in Springfield, and the premiums being paid were not supporting the care," he said. "If you narrow your network, you can lower your expenses."

Physician deselection is extraordinarily unusual for the plan, Dr. Schwartz said. "During the prior year and a half, we had terminated only two or three physicians."

Driven largely by market forces, Dr. Schwartz said PersonalCare offered contracts to specialists who would accept lower reimbursement rates, provided that the HMO sent those physicians additional patients. "If you give a smaller number of providers more patient referrals, other physicians will have to be dropped from the plan," he explained. After these reductions, the HMO's Springfield area physician network numbered about 190 – down from the 210 pre-deselection total.

Although PersonalCare didn't meet SIU Physicians & Surgeons reimbursement requirements, Tkach noted that other HMOs have.

Regarding the timing of the cuts, Dr. Schwartz said there's no ideal time to terminate a contract with physicians, and denied any intention to deceive customers. He pointed out that the plan has several different open-enrollment periods.

The deselection experienced by SIU Physicians & Surgeons and Prairie Eye Center underscores the need for physicians to truly understand the managed care contracts they sign, said ISMS Counsel Saul Morse, who noted that physicians must realize that they can be deselected at any time.

Additionally, learning whether there is a deselection appeal process is also important. "Physicians should find out if they have the ability to change their managed care contract once it's been signed," Morse added.

PersonalCare's physician contracts provided due process for any termination with cause, according to Dr. Schwartz, but not for simply ending a business relationship. Physicians should seek an explanation for their termination, Morse said. "As often as not, a managed care plan will say deselection is an economic decision and is not based on quality of care."

If an HMO does terminate a physician with cause, the decision must be reported to the National Practitioner Data Bank; the state licensing authority may subsequently decide to hold a discipline hearing. The physician whose professional reputation is at stake is more likely to fight the deselection. "That ups the legal ante for all sides, and HMOs prefer to avoid that kind of battle," said Morse.

Another path physicians can take to protect themselves from immediate deselection is to have due process rights added to their contract with an HMO, said Stephen Weiser, a partner in the Chicago law firm Michael Best & Friedrich. "I think the most likely way that might occur is if physicians negotiate a contract as an IPA," he added.

In SIU's case, discussions with PersonalCare had initiated prior to becoming incorporated as a single group. Now that the physicians have been transformed from 150 independent contractors to one large entity, they intend to flex a newfound strength when signing future contracts. "In order to provide better care and access to patients, we will only ratify group contracts," said Tkach. "We're either all in or all out." ■

New Web site provides practice guidelines

A new Internet resource designed to expand access to clinical practice guidelines for health care professionals was recently launched by the Agency for Health Care Policy and Research.

The National Guideline Clearinghouse, accessible via the World Wide Web at www.guideline.gov, was developed by the AHCPR in partnership with the American Medical Association and the American Association of Health Plans.

Available free of charge, the NGC offers health care providers fast access to an increasing number of guidelines. It also tracks distinctions in content, recommendations and developmental methodology for specific guidelines, and provides users with the complete text whenever possible. For fast navigation, the NGC also includes standardized abstracts, comparisons with guidelines covering similar topics and links to e-mail groups to facilitate information exchange regarding development, content and implementation.

New guidelines are being indexed regularly. Organizations interested in contributing material to the NGC are requested to submit two typed paper copies of each guideline and related background information; an electronic version on disk if available; and the name, business address, telephone and e-mail address of a contact person to Vivian Coates, NGC project director, ECRI, 5200 Butler Pike, Plymouth Meeting, PA 19462. ■

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ISMS drives helmet bill for kids

BY PAULA KRAPF

Nearly 75 percent of children's bicycle-related fatalities could be prevented with a bicycle helmet, according to a Washington, D.C.-based consumer protection group, yet here in Illinois opponents of a bike helmet bill recently introduced in the Legislature may slam the brakes on the measure.

"Bike-related fatalities have decreased by 60 percent in New Jersey in the five years the state has had a helmet law for children ages 13-and-under," said Arthur Traugott, MD, chairman of the ISMS Board of Trustees, citing National Safe Kids Campaign statistics.

To bring similar results to Illinois, ISMS supports H.B. 802, which requires all passengers and operators under 16 years old to wear a helmet while riding a bicycle, motorized pedacycle, motor-driven cycle or motorcycle.

The legislation, co-sponsored by Reps. Eileen Lyons (R-LaGrange) and Sara Feigenholtz (D-Chicago), is in step with an ISMS House of Delegates policy recommending legislation requiring children on bicycles and motorcycles to wear helmets.

Feigenholtz concedes that the motorcycle contingent will try to drive the bill off the House floor, fearing its passage would lead to adult helmet laws. But, she said, the debate should focus on saving children's lives. "Children need structure, boundaries and rules, and I believe parents want us to help them by adopting this law."

Office of the Lieutenant Governor

Lt. Gov. Corinne Wood examines breast cancer cells at a Northwestern University lab in Chicago. Wood, a breast cancer survivor, is working to increase breast and cervical cancer research donations on 1998 Illinois tax forms. She is also promoting legislation to name the fund after the late Sen. Penny Severns, who Wood said was the driving force to start the fund in 1993.

Society stands to benefit from a helmet law, said Dr. Traugott. "Children are our most valuable asset, and we need to protect their well-being."

Other bills brewing

ISMS is championing a number of bills that are currently before the General Assembly, ranging from requiring prompt payment for medical services to establishing a single physician credentialing system.

Bills pending in the Legislature that have ISMS' full support include:

• **Delay or denial of payment and conflict of interest.** H.B. 1118, sponsored by Rep. Edgar Lopez (D-Chicago), would prohibit insurers from denying payment for medically necessary inpatient admissions and related services simply because the patient or physician has unsuccessfully attempted to notify the payer and would require all health carriers to pay for claims within 30 days, including payments made under a capitation agreement. In addition, it would call for delinquent carriers to pay 9 percent interest on late payments, and state regulators would be required to investigate physicians' or patients' complaints that their claims were not paid on time. A second component of the bill would prohibit insurance companies, health service corporations and their agents or subcontractors from providing participating physicians with bonuses, or from withholding compensation, as a way of controlling the amount and cost of care provided to insured patients.

• **Death penalty/medical practice.** H.B. 926, sponsored by Rep. Tom Ryder (R-Jerseyville), would ensure that the Department of Corrections could not request, require or allow any licensed physicians to participate in an execution.

• **Clinical privileges for certified registered nurse anesthetists.** H.B. 553, sponsored by Rep. Angelo "Skip" Saviano (R-River Grove), would license certified registered nurse anesthetists similar to the licensing for advanced practice nurses that the General Assembly enacted last year.

• **Definition of surgery.** H.B. 874, also sponsored by Saviano, would amend the Medical Practice Act to define surgery because Illinois statute does not currently contain a definition of surgery.

• **Hospital peer review good faith immunity.** H.B. 2303, sponsored by Rep. Jay Hoffman (D-Collinsville), would amend the Hospital Licensing Act to remove the absolute immunity provision in order to make a hospital and employees and staff members involved in peer review liable for civil damages only in the event of willful or wanton misconduct.

• **Health care professional credentialing act.** H.B. 1780, also sponsored by Saviano, would establish a single credentialing system so physicians would submit basic credentialing information to a single entity. Any organization that wants to credential a doctor would have to obtain basic data from the physician-designated entity. ■

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EDITORIAL

The check's STILL not in the mail

In February, with payments from one HMO running three months in arrears to Belleville otolaryngologist Larry Dobbs, MD, his office called the company to find out what had happened to the money.

All claims processing was on hold, they were matter-of-factly told. The delay was due to an internal audit under way at the HMO. When will payments resume? When the audit is done, of course. When will that be? The employee seemed as incredulous about the query as the guard at the entrance to the land of Oz when Dorothy asked when she and her friends could see the Wizard. "It will happen, but I don't know when."

As discussed in the Jan. 22 Illinois Medicine story, "The check's NOT in the mail," the problem of insurance carriers, Medicare and Medicaid delaying payments to physicians is widespread and growing. According to published reports, some large carriers at any given moment are sitting on hundreds of millions of dollars that belong to physicians and other health care providers.

The example provided by Dr. Dobbs illustrates the hardship for physicians – particularly those in a small solo practice – when outside forces tie up the payments owed them. One claim alone was for $850. The total of outstanding claims delayed by the same carrier amounts to thousands of dollars. Physicians are left without the means to pay their owns bills – insurance, rent, employee salaries, supplies and equipment purchases – which still come due, even when payments to the doctor are delayed.

Some carriers deliberately hold the money due physicians to earn interest for themselves. It has been estimated that a large HMO can earn up to $400,000 a day from interest earned on owed money.

ISMS has launched a campaign to rectify this practice, and it needs physicians' help. The Society has begun to gather details from physicians about the reimbursement delays they encounter. Like the example provided by Dr. Dobbs' office, physicians should come forward with carrier names, amounts owed and length of payment delays.

The Society will review the data, documentation and anecdotal experiences, evaluate the systemic problems and: (a) address individual problems with specific payers as needed, and (b) bring recommendations to the appropriate entity to ensure the hassles are addressed through legislation, regulation or legal action.

To report incidences of payment delay, fill out the short form supplied on page 5 and mail it to ISMS, Health Care Finance Department, 20 N. Michigan Ave., Chicago, IL, 60602; or fax it to (312) 782-2023. The information can also be called in to ISMS at (800) 782-ISMS; or e-mailed to hcfinance@isms.org.

PRESIDENT'S LETTER

New data bank could cast another net to snare physicians

Richard A. Geline, MD

The project looks suspiciously like yet another turn of the ratchet on unsuspecting physicians.

For more than a year, the topic of fraud and abuse – and its manifestation in a set of onerous guidelines we've come to know and despise by the shorthand "E&M" – has echoed through physicians' discussions in settings ranging from doctors' dining rooms to the floor of the AMA House of Delegates.

Generally the discussion emanates from provisions of the Balanced Budget Act of 1997 establishing harsh monetary penalties for violations. More quietly, however, a new front has emerged. The Health Insurance Portability and Accountability Act of 1996 provided for creation of yet another bureaucracy called the Healthcare Integrity and Protection Data Bank.

Need for the new data bank (as distinguished from the existing National Practitioner Data Bank) is based on the questionable estimate of annual losses due to health care fraud and abuse ranging from $30 billion to $100 billion a year. It is to be leveled not only at physicians, but also at equipment providers and suppliers; practitioners including nurses, chiropractors, podiatrists, emergency medical technicians, physical therapists, pharmacists, clinical psychologists, acupuncturists, dieticians; and licensed or certified alternative medicine practitioners, such as homeopaths and naturopaths.

The HIPDB will be a national health care fraud and abuse data collection program for reporting and disclosure of certain final adverse actions taken against health care providers, suppliers and practitioners according to the U.S. Department of Health and Human Services. It will contain information on civil judgments, criminal convictions and administrative actions related to health care delivery that can be used to exclude the provider, supplier or practitioner in question from participation in federal or state health care programs. Most ominously, the rules call for it to include "any other adjudicated actions or decisions that the Secretary [of HHS] establishes by regulations."

HHS interprets the empowering statute as an indication Congress clearly intended a broad interpretation of the term "health care fraud and abuse." HHS believes reporting should include: "all reportable final adverse actions . . . that are inconsistent with accepted sound fiscal, business or medical practices, directly or indirectly, resulting in unnecessary costs to the program; improper payment; services that fail to meet professionally recognized standards of care or that are medically unnecessary; or . . . violation of contractual arrangements, or delays in diagnosis or treatment."

Although confidentiality is intended, the proposed rules indicate a notice will be published for public comment for purposes of establishing a *Privacy Act exception* for the HIPDB. That is chilling.

Another nugget buried within 36 dense pages of rules is an option to reduce the reporting burden of state licensing and certification agencies by having respective professional organizations serve as the authorized agents to report to the HIPDB. That should create some interesting debate at state medical society boards nationwide.

The AMA has strongly expressed its concerns that the HIPDB casts too wide a net that will ensnare not only those engaged in true fraud but also those who commit inadvertent billing errors. The information to be collected is "so extensive that it would serve little purpose but to provide an opportunity for government enforcement agencies to conduct fishing expeditions," the AMA told HHS.

What does all this mean for physicians? Perhaps little. One theory is that government efforts will be directed away from physicians and toward pharmacists, durable medical equipment providers, hospitals and others. On the other hand, the project looks suspiciously like yet another turn of the ratchet on unsuspecting physicians by an Orwellian Big Brother-type government.

Either way, the HIPDB provides another mission for organized medicine. Monitoring this matter on behalf of patients and physicians is essential. It represents another example of the value of your dues dollar to professional organizations at all levels.

GUEST EDITORIAL

Physician profiling – or physician-directed profiling?

By John Schneider, MD


John Schneider, MD

In today's world where information flows from many points, physicians must be tough watchdogs guarding against profiles created with easily gathered data that are not necessarily accurate.

At a glance, profiling may appear harmless. By the most straightforward definition, physician profiling is simply a set of data portraying the significant features of a physician's practice. But at closer inspection, there is plenty of room for damage unless attention is paid to how the data are obtained, what data are needed, and – arguably most important – how their accuracy are ensured.

Data are available in a variety of forms: Medicare claims information, statistics on hospital charges, and records of physician malpractice experience, to name a few. But collecting data is not an inexpensive endeavor, and because it can get pricey, there is an incentive for organizations to use readily available information. The hazard for physicians is that the information that is easy to obtain may not provide an accurate profile of physicians, hospitals or other health care providers.

Consider, for example, the annual rankings a variety of publications create that evaluate hospitals. Often, there is no mechanism of verification in these publications to ensure their information is accurate. This renders the profiling not merely inappropriate, but dangerously misleading.

Physicians must take care that this type of evaluation is not leveled at them under the guise of "profiling." To be meaningful, profiling must start with specific questions or an objective. The goal of collecting that information should be to enable physicians and other health care providers to improve the efficiency, effectiveness and quality of care.

This, of course, requires the involvement of physicians and physician organizations in determining relevant questions and developing appropriate objectives. A process to select and collect information that will be reflective of the care must be developed and validated. Included in this category would be information necessary for physicians if they wish to participate in capitated care. To effectively participate in a capitation program, one needs to know what the costs and quantity are of the services that a physician will be providing to patients enrolled in a plan.

The physician would need to profile his or her experience over the course of the year so appropriate capitation payment would ensure that the necessary and appropriate care could be provided in future years. The insurer would need similar information to judge the care needs of individuals enrolled in their health plan. Second, to assess quality of care, to enable physicians or practice groups to improve that quality, information is most accurately collected at the level of the particular practice plan. The purpose should not be to punish individuals financially or otherwise because of their profiles, but to enable individuals to improve their practice.

Profiles cannot be the exclusive domain of an insurer, managed care entity or HMO; if such an organization collected data only on its enrollees (the likely approach), the numbers would more than likely be too small to be effective. Physicians report that their experience in a given procedure may differ depending upon the group of individuals who are covered by each insurance plan. To correctly profile and to enable physicians to improve their practice, one needs to know the total experience of the physician.

To ultimately assess quality of care, and thus enable physicians or practice groups to improve that quality, information is most accurately collected at the physician practice level. Only there, can one be assured of accurate, appropriate data collection.

An example of effective data collection for profiles recently emerged in New York, where physicians helped develop profiles of cardiovascular surgeons and the care they provided during and after surgery. The immediate impact of this effort produced a corresponding decrease in the surgical mortality rate. The episode exemplifies how improving patient care should be the primary objective in creating any physician profile. When patient care is the foundation of our efforts, the results have the greatest chance of benefitting patients' overall health.

To facilitate the creation of effective profiles, and reinforce the importance of keeping patient well-being at the heart of any such effort, physicians must help develop plans that best assess personal qualifications, care environment, clinical performance, patient care results and credentials. Such programs will provide opportunities for physicians to ensure that profiling is being done first and foremost to improve the effectiveness of the care they are providing.

As physicians dedicated to the well-being of our patients, we must accept the challenge of directing the data collection efforts that will drive our profiles. Without our intimate involvement in the process, we risk wrangling with the inadequate, often inappropriate profiling performed by others. Think of what risks that might bring upon our patients. ■

John Schneider, MD, is immediate past chariman of the ISMS Third Party Payment Processes Committee.

Is your mailbox empty?

ISMS wants to hear from physicians about the reimbursement delays they encounter. Please fill out this form to receive ISMS assistance collecting overdue payments. Data provided by physicians will also be used to compile evidence that ISMS can use in its campaign to reduce payment delays. Mail to: ISMS, Health Care Finance Department, 20 N. Michigan Ave., Chicago, IL 60602; call in to ISMS at (800) 782-ISMS; or e-mail to hcfinance@isms.org.

Name _____

Address _____

City _____

IL ZIP _____

Phone _____

Outstanding amount _____

How long is the payment overdue? _____

Is this hassle a: ❒ first-time problem? ❒ recurring problem?

Identify organization causing the delay: _____

Type: Managed care ❒ Government ❒ Indemnity plan ❒ Independent Practice Association ❒

If possible, include documentation supporting your claim.

ISMS online

- Breaking news
- Physician advocacy information
- Springfield and Washington reports
- Patient health resources
- Links to ISMS services

To visit ISMS' home page, go to www.isms.org on the Internet.

Online feature:
The ISMS Web site, *ISMS Online*, includes the latest licensing requirements, guidelines, and interpretations addressing continuing medical education in Illinois.

Click on the Education/CME section for more information.

Coming soon:
What physicians need to know about the Hepatitis C look-back

ISMIE Update

Upcoming ISMIE seminar

RISK MANAGEMENT: AN ESSENTIAL OFFICE PRACTICE
March 31, Northbrook
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Direct-to-consumer drug advertising: Hype or help?

Illustration by Olivia

BY MARGARET VEACH

Since the U.S. Food & Drug Administration lifted its moratorium on direct-to-consumer prescription drug advertising in 1985, consumers in this country are as likely to see glitzy ads for Claritin as for Clairol, for Propecia as for Pop-Tarts.

And the simple fact that as many as 95 percent of physicians surveyed in 1997 said their patients had requested advertised drugs by name says something about the success of ads directed to consumers. Although visits to physicians overall rose only 2 percent between January and September 1998, visits for conditions for which drugs were heavily advertised rose 11 percent in that same period.

It's easy to see why. According to an audit report by Scott-Levin, a pharmaceutical consulting company, 49 new drug ad campaigns were launched during the first 10 months of 1998, to the tune of $1.1 billion – about half of that for television ads alone. Drug companies spent more last year to promote their products to consumers than to medical professionals, the report stated.

Although it has been 14 years since the FDA lifted its moratorium, the practice of promoting prescription drugs through the mass media is still controversial. Do DTC ads effectively educate consumers? Or do they simply raise awareness of a product?

Physician response is mixed. Some physicians say the ads enhance physician-patient communication and create better-informed patients. Samuel Schimel, MD, a family physician in Chicago, said he believes patient requests for advertised drugs provide an ideal opportunity for doctors to educate their patients. "Yes, it takes more time, but it's important to explain the pros and cons of the prescription they are requesting," said Dr. Schimel. "It's also important for patients to understand why or why not you are prescribing that advertised drug."

Concerns raised by physicians are that the ads mislead consumers, do not include enough information, promote reliance on medication, undermine the physician-patient relationship and increase costs.

Martin Goldstone, MD, a River Grove internist, said he doesn't believe DTC ads are particularly helpful because of the information they leave out. "Patients aren't necessarily well-informed; they just see a drug advertised on TV and tell me they want to try it, or they say their friends have tried it," he said.

"Patients usually have the name of only one drug and think it's all that's available for their condition," said Donald Graham, MD, a Springfield infectious disease specialist and chairman of the ISMS Committee on Drugs and Therapeutics. "It's important that physicians explain all the therapies available," he said.

"I find it more helpful when patients bring in a newspaper or journal article that discusses treatment options than when they simply ask me about one drug advertised on TV," added Dr. Graham. "That way we can talk about what they've read."

Although drug ads do emphasize that patients should talk with their doctors, the potential for consumers to view heavily advertised medication as simply another new product to try on demand is troubling to many physicians. Dr. Goldstone said that he has felt pressured by some patients to prescribe advertised medications. "When there is a possibility that the medication could help the patient's condition, sometimes I do give in," he said. "But I certainly wouldn't prescribe it if I thought it would harm the patient."

"Physicians shouldn't be persuaded to prescribe something just because a patient requests it," said Robert Baron, an attorney with Rooks, Pitts & Poust in Joliet. "They should prescribe it because they've thought the situation through – that is, is this advertised drug what they would prescribe anyway for this particular patient with this condition?"

Doctors should prescribe DTC-advertised drugs just as carefully as they do any other medication, experts advise. "As long as the physician makes sure the patient is an appropriate candidate for the labeled use of the advertised drug, there shouldn't be any potential for liability," said Alan Kaplan, a partner with Kleinfeld, Kaplan & Becker, a Washington, D.C., law firm that deals solely with pharmaceutical matters. "The physician must also disclose side effects for which the patient should watch."

Whether doctors believe DTC drug advertising helps consumers or simply hypes products, the fact is that it is here to stay. Richard Snodgrass, MD, a Moline cardiologist, takes a positive outlook on the trend. "I see nothing wrong with drugs being advertised to consumers," he said. "I'm a believer in patients being informed." ■

Who can advertise? There are no restrictions on the types of drugs that can be advertised to consumers, said Nancy Ostrove, chief of the marketing communications branch in the Center for Drug Evaluation and Research of the FDA. "In fact, even 'boxed-warning' drugs – pharmaceuticals that carry serious risks of death or hospitalization – can be advertised directly to consumers," she said.

Ostrove explained that certain types of drugs seem to be advertised more than others because they treat common conditions about which consumers are frequently concerned, such as heartburn, allergies, and toenail fungus.

Tips physicians should follow when patients insist on prescriptions for heavily advertised drugs:

Rx WITH CAUTION

- Hold the line against prescribing a drug that may not be appropriate.
- Keep a record of all patients on new medications so you can tell them if you learn of any adverse reactions.
- Inform patients of side-effects and interactions – and document in their medical record the fact that you informed them.
- Immediately notify patients of new complications and developments involving a prescription they are taking, and document that notification.
- Advise patients if a prescription drug they are taking is withdrawn.
- Before prescribing, ask patients about any natural medications they may be taking.

Physical restraint demands common sense and caution

BY JOY LE VEE

An alert warning health care providers about deaths of patients who had been physically restrained was recently issued by the Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission began tracking restraint deaths two years ago, and has since reviewed 20 such cases, including the following:

- A preteen who had been acting aggressively in a psychiatric unit died of suffocation after a staff member used a therapeutic hold to bring him to the ground.
- A patient in restraints who was yelling and spitting died of suffocation after a towel was placed around the patient's mouth.
- A violent man brought to a hospital emergency room died of burns after he tried to burn off his restraints with a cigarette lighter.

According to the Joint Commission, it is impossible to say how often physical restraints result in death because only New York state has a reporting system that includes information about restraints. "There is good evidence that restraint deaths occur more frequently than we know," said Paul Schyve, MD, Joint Commission senior vice president. "We tend to learn of these deaths from the media, usually after a lawsuit is filed."

Of the 20 cases analyzed, 12 occurred in psychiatric hospitals, six in general hospitals, and two in long-term care facilities. In 40 percent of the cases, the cause of death was asphyxiation. The remainder were caused by strangulation, cardiac arrest or fire. All of the strangulation deaths were of geriatric patients in vest restraints, who in most cases died when they slipped between unprotected split side rails.

The Joint Commission's standards on the use of physical restraints were updated in 1995. "The fundamental principle is that restraints should not be used except when absolutely necessary," Dr. Schyve said. "They are not to be used as punishment, or for the convenience of staff. Health care organizations should always strive to find alternatives."

James Neville, an attorney with Neville, Richards, DeFranco & Wuller, a Belleville defense firm that specializes in medical malpractice, recommends that physicians using physical restraints comply with standards of care established by experts in their own specialties. "Physicians should always document the indications for restraints, and how they are to be used," he said.

Restraints typically are used on three patient groups: acute medical/surgical patients to prevent them from pulling out tubes; psychiatric patients who threaten to harm themselves or others; and elderly patients, especially those suffering from dementia, to prevent them from wandering at night or falling.

Suggestions for reducing risk of restraint deaths include:

- Use risk assessment and early intervention to reduce the use of physical restraints and therapeutic holds.
- Revise procedures for assessing the medical condition of psychiatric patients.
- Enhance staff orientation/education regarding alternatives to physical restraints and proper application of restraints or therapeutic holds.
- Consider age and sex of patients when setting therapeutic hold policies.
- Continuously observe any patient who is restrained.
- Do not restrain a patient in a bed with unprotected split side rails.
- Discontinue use of certain types of restraints, such as high vests and waist restraints.
- Ensure that patients do not have access to smoking materials, including any supplied by family and friends. ■

ISMIE offers legal-defense reimbursement coverage

Beginning July 1, ISMIE's professional liability insurance will reimburse legal defense expenses for policyholders who face licensure and/or disciplinary action or sanction.

All "ordinary and necessary" legal expenses required to defend the insured physician, such as attorney fees, court reports, transcripts, filing fees, travel expenses and expert witness fees, are covered.

"We are happy to offer this added value to ISMIE's professional liability insurance policy at no additional premium," said Harold Jensen, MD, chairman of the ISMIE Board of Governors.

Reimbursement coverage is limited to proceedings brought by the state regarding a medical license. Such proceedings would include any investigation or action brought against an insured physician in which the outcome could result in discipline against the physician and/or his or her medical license.

A request for reimbursement of legal expenses must be received and acknowledged by ISMIE while the policy is in effect. Only physicians insured with ISMIE at the time expenses are submitted are eligible for reimbursement. The maximum reimbursement per physician per policy period is $25,000, subject to a $2,500 deductible. For more information on this new policy feature, call (312) 782-2749, and ask for the underwriting department. ■

PATIENT RIGHTS ALL-STARS

Lawmakers who have made the right moves for patient rights legislation

BY PAULA KRAPF

As ISMS begins its full-court press to pass patient rights legislation this year, the Society has high praise for a stellar lineup of senior and new legislators who have carried the ball for patient rights in past battles. In some cases, members of this bipartisan team have pushed their way past party lines to make key plays.

The old-timers, who lost their fiercely contested battles in the General Assembly last year to pass either H.B. 974 or S.B. 1904, begin the new legislative season still bearing scars from 1998. Despite any defensive roadblocks they may encounter, these primo players are expected to mount a determined offensive charge for patient rights in the 91st General Assembly.

Top performers on the patient rights roster have racked up impressive stats and include the following all-stars:

Rep. Mary Flowers (D-Chicago)

★ Patient rights stats: If there's a scrimmage for patient rights in the General Assembly, look for Flowers in the middle of the fray as chairman of the Health Care Availability and Access Committee. While Michael Jordan wore No. 23, Flowers could very well have 626 on her jersey to signify H.B. 626, a comprehensive patient rights bill she introduced last year and that was knocked out in the Senate because it would give patients the right to sue their HMO. This year is no different. Flowers has introduced the same bill, with the same number.

Rep. Tim Johnson (R-Urbana)

★ Patient rights stats: During the 1998 drive for patient rights, Johnson was one of only four Republicans to support last year's bill that would have given consumers the right to sue their managed care plans. Johnson's game plan for 1999 isn't much different, and he hopes that members of the Legislature will iron out their differences so that Illinois consumers will have a victory.

Rep. Gwenn Klingler (R-Springfield)

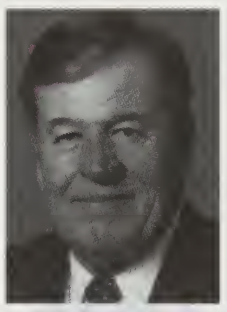
★ Patient rights stats: Klingler has tried to keep the clock from running out before the General Assembly can adopt a patient rights law. She was another of the four Republicans to support last year's bill that would have given consumers the right to sue their HMOs. This year she is firmly behind H.B. 579, the ISMS-supported managed care patient rights bill. Klingler is married to ISMS member W. Gerald Klingler, MD.

Rep. Carolyn Krause (R-Mt. Prospect)

★ Patient rights stats: The House leading Republican advocate of managed care reform, Krause in last year's primary withstood a challenger largely funded by managed care reform opponents. This year Krause leapt off the bench to sign on as one of H.B. 579's five principal sponsors. She is minority spokeswoman on the House's Health Care Availability and Access Committee.

"We are grateful to those lawmakers who clearly put patient rights first by taking such a strong stand for reform."

– ISMS Chairman of the Governmental Affairs Council Nestor Ramirez, MD



Sen. Robert Madigan (R-Lincoln)

★ Patient rights stats: A steady ball carrier for patient rights in the Senate, Madigan can be counted on in a close game. He is sponsoring a bill this session to require insurance companies to make prompt payment to physicians. Madigan is chairman of the Insurance and Pensions Committee in the Republican-dominated Senate.

Rep. Bill Mitchell (R-Decatur)

★ Patient rights stats: Newly elected to the House in November 1998, Mitchell wasn't a part of last year's losing effort to pass a patient rights bill in the General Assembly. But his campaign for a House seat last fall tipped off his willingness to score points for patient rights – including a campaign promise to support consumers' rights to sue their health care insurance carrier.

PATIENT RIGHTS ALL-STARS

Rep. Angelo "Skip" Saviano (R-River Grove)

★ Patient rights stats: This Republican is always on hand to make an assist when it comes to patient rights legislation. He was one of the four Republicans last year to support the bill that included HMO liability. Saviano has established a presence on the court in this session of the Legislature by generating momentum for H.B. 579 and H.B. 626.

Rep. Jeffrey Schoenberg (D-Evanston)

★ Patient rights stats: As captain of this year's health plan reform squad, Schoenberg took his support of patient rights to center court and became a lead sponsor of H.B. 579, the ISMS-backed patient rights bill. He has taken a leadership role in patient rights before, sponsoring the ISMS comprehensive managed care patient rights bills in 1996 and 1997.

Sen. Thomas Walsh (R-Westchester)

★ Patient rights stats: The Senate's designated hitter for patient rights is the chairman of that chamber's managed care subcommittee. Following a series of hearings held throughout the state to gather testimony from citizens, the subcommittee last year wrote H.B. 974, an ISMS-backed managed care reform bill. He wants 1999 to be the year that patient rights legislation reaches home plate.

"These legislators have made courageous and historic steps toward curbing managed care abuses and ensuring every patient's right to quality care."

– ISMS President Richard Geline, MD

Congressional team:

U.S. Sen. Dick Durbin (D-Illinois)

★ Patient rights stats: Sen. Durbin scored for patients in 1997 when he proposed a bill to hold HMOs accountable for injuries that result from their direction of a patient's medical care. He can be expected once again to initiate a full-court press for patient rights in Congress. His goal is to give doctors control over medical decisions and patients the fullest possible protections.

U.S. Sen. Peter Fitzgerald (R-Illinois)

★ Patient rights stats: In the Illinois General Assembly, Fitzgerald was a frontcourt player for patient rights who supported consumers' right to sue a health insurance carrier. He is expected to carry that commitment into the U.S. Senate. In addition, Fitzgerald was a key player in efforts at tort reform in Illinois – another battle that he may continue in Congress.

Ryan's Picks: New Gov's health care cabinet an all-star lineup

A selection of accomplished veterans will be joined by some talented newcomers to aid Gov. George Ryan's nascent administration on health care issues.

Ryan's picks to head health-related cabinet posts are led by returning Illinois Department of Public Health Director John Lumpkin, MD, who has held the position since 1991.

"Dr. Lumpkin is well respected by his peers in Illinois as well as nationally, and the governor believes the DPH is heading in the right direction," explained Nick Palazzolo, a spokesman for the governor.

"We are pleased that Gov. Ryan has chosen such a solid team to provide leadership for health care issues in Illinois," added ISMS President Richard Geline, MD.

Ryan's department directors – which require Senate confirmation – also include:

Department of Professional Regulation: Leonard Sherman, 49, previously the director of administrative hearings for the secretary of state's office.

Department of Human Services: Howard Peters III, 53, who had served as DHS secretary since the department's formation in 1997.

Department of Public Aid: Ann Patla, 54, who previously served as the associate secretary for the DHS.

Department of Insurance: Nat Shapo, 31, who previously served as a research and program development coordinator for the secretary of state's office.

Department on Aging: Margo Schreiber, 61, who was formerly the administrator for the DuPage Division of Human Services.

Department of Central Management Services: Michael Schwartz, 46, reappointed to the post of director.

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Audit shows dramatic decline in Medicare overpayments

AMA demands clarity on mistakes vs. fraud

Improper Medicare payments to hospitals, physicians and other health care providers declined last year to the lowest error rate since the government initiated comprehensive audits three years ago, according to a report recently issued by the U.S. Department of Health and Human Services.

The error rate for fiscal year 1998 was an estimated 7.1 percent, representing estimated improper payments of $12.6 billion, an audit prepared by the HHS Office of Inspector General concluded. This compares with an error rate of 11 percent ($20.3 billion) in fiscal year 1997 and 14 percent ($23.2 billion) in fiscal 1996.

Although the improper payments ranged from inadvertent mistakes to outright fraud and abuse, the portion of the error rate attributable to fraud could not be quantified, the report stated.

The American Medical Association quickly lashed out against the report, expressing frustration with the OIG for continually failing to properly distinguish between honest billing mistakes and true fraud.

"The AMA has urged the administration to increase its educational efforts for practicing physicians who honestly may not be aware of their inadvertent billing errors," said AMA President Nancy Dickey, MD.

The report identified two major problem areas: billing for services that were not medically necessary and upcoding services to secure a higher reimbursement than justified. They combined to account for approximately $9.3 billion of the estimated $12.6 billion in improper payments. Another $2.1 billion was attributed to documentation discrepancies and the remaining $1.2 billion to billing for services not covered by Medicare, as well as other types of errors.

Dr. Dickey said the AMA wants the administration to temper its rhetoric and refine its program initiative so that those physicians honestly participating in the Medicare program are not subjected to the federal government's overly aggressive punitive approach.

Medical reviews coordinated by the OIG detected 90 percent of the improper payments. In one example, a physician billed Medicare $871 for 40 hospital visits. The medical records, however, supported only 18 visits. In all instances in which improper payments were specifically identified, action was taken to deny the claim and recover the overpayment.

Inspector General June Gibbs Brown attributed the reduction in improper payments to several factors, including improved program oversight and enforcement, and greater compliance by health care providers with Medicare's billing rules. She credited the U.S. Health Care Financing Administration for requiring more extensive prepayment reviews of types of claims identified as vulnerable to improper payments. ■

Physicians, nursing homes should expand communications

The Illinois State Medical Society will send a letter to the Illinois Hospital and HealthSystems Association informing it of a new Society policy that encourages physicians, hospitals and nursing homes to better share clinical information about patients.

Sending the letter fulfills a resolution the ISMS House of Delegates adopted at the 1998 Annual Meeting. That resolution called upon ISMS "to encourage physicians and hospitals to report pertinent clinical information back to nursing homes following discharge, even if the patient does not return to that nursing home."

The House of Delegates determined that the physician should decide what clinical information would be relevant to the patient's care, but, at a minimum, the hospital discharge summary should be given to the nursing home.

Any transfer of information should also include safeguards that ensure the patient's confidentiality is protected, delegates said. ■

ISMS educates physicians on appropriate medical donations

BY PAULA KRAPF

Whether providing humanitarian aid to patients in war-torn Nicaragua or economically devastated Haiti, Donald Graham, MD, often faces the same dilemma: well-meaning physicians have donated unusable medical supplies and medications.

"It's like giving old clothes to Goodwill – if the clothes require a lot of repairing and cleaning, they are useless," said Dr. Graham, who is the chief of the department of infectious disease at Springfield Clinic. Since 1986, Dr. Graham has undertaken "umpteen" medical missions to Third World and poorly served countries that seek medical assistance from the United States. During those trips he has seen countless medical donations go to waste.

Dr. Graham brought his concerns to the Sangamon County Medical Society, which last year introduced a successful resolution at the ISMS Annual Meeting to educate physicians about making appropriate medication donations.

The goal is to encourage potential donors to follow three basic tenets: ask the agency sponsoring the medical mission for a list of appropriate medications to send (or refer to the World Health Organization's Model List of Essential Drugs, which is online at www:who.int); don't donate medications that are at or near expiration; and repackage medications into usable quantities in clearly labeled containers.

Dr. Graham noted some common problems that render seemingly appropriate donations useless. Sample packages of medication, for example, do not contain a sufficient quantity for ongoing therapy. Newly available drugs are often not suitable for donations; Third World medical practitioners may be unfamiliar with new drug treatments.

In addition, strict laws govern physicians' ability to donate sample medications both in the United States and foreign countries. Recipient countries, which are often financially strapped, bear the cost of storing, handling and disposing of useless drugs, he said.

Even packaging makes a difference; oversized boxes filled with a variety of small packages force receiving physicians to catalogue those samples, taking time away from treating patients. Whenever Dr. Graham leads a mission, he enlists neighbors and church members to sort medications at a "pill party" prior to departure.

There are often limitations to the care physicians can provide during a mission. For example, medications that require physicians to closely monitor their patients may be wasted if there is no lab nearby or if the treatment protocol is too extensive, Dr. Graham said.

Donations welcomed by mission teams are bread-and-butter medications, such as penicillin, eye drops, blood pressure drugs and diuretics because they are greatly needed in underdeveloped areas, Dr. Graham noted. Unfortunately, many of these medications are not distributed to physicians as samples. Dr. Graham suggested an alternative for physicians who want to help out: make a cash donation to a medical mission so organizers can purchase appropriate drugs.

The same donation rules apply to equipment. It is wonderful to have, but donors should make sure the instruments function properly, that recipients are trained in their use, or that a user's manual is provided, he said.

Some private organizations that make donations, including pharmaceutical companies, have devised guiding principles to prevent distribution of inappropriate medicines and medical supplies for disaster and humanitarian relief, said Marc Scarduffa, manager of government relations for Pfizer Inc. According to the guidelines, donor companies should:

- Enclose appropriate prescribing information with each package.
- Donate products at least 12 months prior to the expiration date so that processing delays don't invalidate the donation. (An exception to this rule is if the recipient institution confirms that the product will be used before it expires.)
- Package pharmaceuticals in sealed, finished containers suitable for export and labeled with the drug's generic name, proprietary name, expiration date, manufacturer's and/or distributor's name and address, special storage requirements, quantity, strength and dosage unit.
- Discourage pharmaceutical sample donations because patients won't receive a full course of therapy and the packaging may be difficult to dispose of in the recipient country.

"We appreciate the contributions, but we want to help donors make the most valuable donations," said Dr. Graham. ■

Donor don'ts

State of the State

(Continued from page 1)

resents a 7.4 percent increase from fiscal 1999's estimated expenditures. The Medical Assistance Program, which includes KidCare, is one area that will experience a funding increase. Therefore, MAP payment cycles will remain at their current levels: less than 25 days for all providers and less than 20 days for physicians.

Ryan announced several other health care initiatives, including the following:

• A plan to double the resources available to the Office of Women's Health by adding $1 million to the IDPH budget and asking the General Assembly to approve a new Women's Health Illinois initiative to be overseen by Wood. With the help of the governor's office and IDPH, Wood will be the liaison for approximately 65 women's health-related programs and opportunities that are offered by several state agencies.

• An order for IDPA Director Ann Patla to "untangle the bureaucratic red tape" so the KidCare insurance program can serve up to 155,000 children in the coming fiscal year. The state program offers low-cost health care coverage to children and pregnant women, but many women and children have been prevented from signing up due to glitches, in the form of lack of publicity and an inability to process applications promptly. According to IDPA, inadequate staffing and poorly integrated computer systems have contributed to the enrollment delay. Only about 3,000 of the estimated 200,000 uninsured children who are eligible for the program since its expansion in October 1998 actually participate.

• A suggested IDHS budget of $4.5 billion to strengthen and implement a number of programs, including an allocation of $10.3 million for substance abuse programs for children and public aid clients; $13.5 million, which includes a $5 million increase, for the Teen REACH program that supports after-school activities to combat gang involvement and substance abuse; an increase of $4.5 million to expand Healthy Families Illinois case management services; and an increase of $9.3 million for 276 new Community Integrated Living Arrangements for people with developmental disabilities.

• A tentative IDPH budget of $224 million that includes a funding increase of $1.2 million for improving state regulation of the hospital and long-term care industries. That will be accomplished, in part, by nearly doubling the ranks of hospital inspectors with 15 new hires.

• A continued push to increase the number of organ donors. ■

UIC funding request

(Continued from page 1)

chairman Sen. Steven Rauschenberger (R-Elgin), would earmark $93 million from the state's cash reserve of approximately $1.5 billion to replace UIC's College of Medicine with a state-of-the-art research facility.

By setting aside the funds this way, the state can avoid selling bonds, which, with interest payments over 10 or 20 years, would nearly double the project's total cost, said Rauschenberger. The state has already allocated nearly $9 million for the center's planning and design.

ISMS President Richard Geline, MD, testified in favor of the funding.

"By improving UIC's physical facilities, we can ensure that the next generation of Illinois physicians can learn in the most appropriate environment to provide the best medical care to their patients. I think we owe that to our patients, not to mention to the best and brightest of our young people," he said.

Several committe members asked tough questions about the proposal and whether the school could tap other funding sources. Sen. Donne Trotter (D-Chicago) observed that another UIC expansion plan, the $450 million South Campus residential/commercial project that is under way adjacent to Roosevelt Road, was controversial.

Markus Giolas

Jeffrey Gindorf, MD

The university has sought private funding for the project, although UIC got into the fund-raising game late, so it lacks the considerable endowment of its peers, said David Broski, UIC's chancellor.

The project is planned in two stages. Phase one, slated for completion in 2003, would house 110 investigators and 80 laboratories, while the second phase, funded through private donations and other sources, would develop shell space for future growth that could accommodate 30 investigators. Research would examine critical medical problems including cancer, cardiovascular disease and stroke, neurodegenerative disorders and psychiatric diseases, and develop new approaches to medical care using gene therapy and image-guided surgery, said Gerald Moss, MD, dean of the University of Illinois College of Medicine.

UIC officials observed that its medical school is the largest in the nation, and it trains one out of every six physicians practicing in Illinois. Without the new facility, UIC will be at a competitive disadvantage for federal research funds, lose its ability to attract top-notch faculty and students and produce less revenue for Chicago, Dr. Moss said.

"We generate $1 billion in economic activity," he said, from sources that include federal research funds and state income tax revenues from UIC employees.

Rauschenberger said his bill will soon reach a vote on the Senate floor. "We'll see then if we have enough support to use state reserves to fund this facility," he added. ■

IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

October 1998

Mark Baldwin, Columbus, OH – physician and surgeon license restored to indefinite probation.

Ricardo Bernales, Berwyn – physician and surgeon license fined $3,000 for providing service to an unauthorized medical laboratory facility.

Michael Fuentes, Evanston – physician and surgeon license indefinitely suspended after being disciplined in the states of Pennsylvania and Massachusetts.

Ronald A. Distelhorst, Schaumburg – physician and surgeon license indefinitely suspended for abandonment of patients and failure to transfer medical records.

Lorenzo Maun, Waukegan – physician and surgeon license fined $5,000 for gross negligence.

Robert L. Wilson, Olympia Fields – physician and surgeon and controlled substance licenses summarily suspended, pending proceedings before the Medical Disciplinary Board, for gross negligence and committing dishonorable, unethical or unprofessional conduct.

The following individuals were ordered to cease and desist the unlicensed practice of medicine after diagnosing and treating patients at the Family Medical Clinic: Boyedi Ademodi, Naperville; Agwuk K. Nwoke, Alsip.

November 1998

Michael Anderson, Hecker – physician and surgeon and controlled substance licenses indefinitely suspended due to drug dependence, writing controlled substance prescriptions for his wife, who was also dependent on the medications, and himself for non-therapeutic purposes and writing prescriptions for family members which were for his personal use.

Cesar Armoza, Chicago – ordered to cease and desist the unlicensed practice of medicine after he offered and performed acupuncture at the Natural Care Center in Chicago.

Camilo Barros, Chicago – physician and surgeon license reprimanded for allegedly failing to perform a complete physical examination on a patient who was later diagnosed with cervical cancer.

Terrold Butler, Chicago – physician and surgeon license reprimanded after allegedly failing to obtain adequate documentation of history prior to prescribing phenobarbital for a patient.

Joseph Dickstein, Chicago – physician and surgeon license placed on indefinite probation and fined $10,000 after three of his patients allegedly experienced complications after surgical procedures he performed, resulting in the revocation of his clinical staff privileges at a hospital. While he is on probation, Dr. Dickstein cannot practice obstetrics or perform any gynecological or other surgical procedures.

Nujim Aldeen A. Jerjees, Berwyn and LaJolla, CA – physician and surgeon license indefinitely suspended for failing to report the settlement of a civil lawsuit to the Department and failing to respond to the Department's requests for information on the settlement.

Jan E. Metz, Quincy – physician and surgeon license suspended for six months followed by indefinite probation, and controlled substance license suspended for three years followed by indefinite probation, due to an alleged history of alcohol and substance abuse and allegedly self-prescribing controlled substances.

Valerie Ann Vickerman Morris, Elgin – ordered to cease and desist the unlicensed practice of medicine after providing prenatal care, examinations, Pap smears, blood work and administration of Rhogam.

Eugene V. Tanski, Oakbrook – physician and surgeon license reprimanded and fined $6,000 for allegedly failing to provide requested information to the Department in a timely manner.

December 1998

Ronald Arthur Distelhorst, Schaumburg – physician and surgeon and controlled substance licenses indefinitely suspended for abandonment of patients and failure to transfer medical records.

Ho Kyung Lee, Chicago – physician and surgeon license revoked after practicing medicine with a suspended license.

Mahmoud Minir Musa, Chicago – physician and surgeon license revoked after being terminated from the Illinois Medical Assistance Program for overcharging the Illinois Department of Public Aid.

Walter J. Sherman, Chicago – physician and surgeon license indefinitely suspended after being disciplined in Indiana, being convicted of a felony, being habitually addicted to alcohol, prescribing controlled substances for non-therapeutic purposes and engaging in dishonorable, unethical or unprofessional conduct.

Madhaviah R. Singa, Westmont – physician and surgeon license reprimanded for allegedly failing to inform a patient of the medical results of a blood test.

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Carle Clinic – BC/BE internal medicine physicians for clinics located in Mattoon and Danville. Seeking experienced physicians possessing high standards /credentials. Carle is a physician-owned and -operated multispecialty clinic providing health care services to approximately 1.3 million residents. Contact Christina Trusner at (800) 436-3095, Ext. 8227, or fax CV to (217) 383-8322.

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As near as your phone

Unfair contract

(Continued from page 1)

coercion. I didn't think it was in my best interest or the best interest of my patients."

Dr. Morris added it was as if the HMO was "trying to put a wedge between physicians and their patients. It made me almost an agent for the insurance company in my patients' eyes. It was unacceptable. All I was saying was, 'Let us have our choice.' "

If health plans see it differently, it would be no surprise to Mark Rust, partner in the Chicago law firm Barnes & Thornburg, and chairman of its Healthcare Practice Group. He unequivocally believes, for example, that "with Aetna, this clause is simply not negotiable. I've been in meetings with them, and they have made it quite clear this clause is the most important part of their contract."

Rust stated that in his view the all-product clause runs afoul of federal antitrust laws. Specifically, he said, at issue is whether this is an example of "tying" – arrangements in which sellers force buyers to purchase an unwanted product (the tied product) in order to obtain a desired product.

While on the face of it the all-product clause would seem to be a tying arrangement, Rust said the court may not see it as clear-cut as that. He noted that the question is whether Aetna is a buyer or seller of medical services. Currently courts are more likely to see them as the buyer and, thus, not covered by tying restrictions. Rust said only litigation will resolve the issue.

Although Aetna is not the only offender in the all-products issue, its strict terms in this area received much publicity in the media coverage following a recently announced and widely denounced Aetna purchase of Prudential Insurance Co.'s health care business. A complaint to the U.S. Department of Justice by the American Medical Association charges Aetna's proposed acquisition would violate federal antitrust laws – including the Sherman Act's and Clayton Act's tying prohibitions. The federal government must approve the purchase.

In late December 1998, the AMA, in a letter from Executive Vice President E. Ratcliffe Anderson Jr., MD, to Assistant Attorney General Joel Klein, expressed "strong concern" about the merger, which, according to published reports, would result in Aetna having contracts with more than half the nation's 550,000 nongovernmental, practicing physicians. Further, the new Aetna would hold sway over health care terms for more than 18 million Americans.

Aetna responded that its Prudential purchase would result in more vigorous competition and a wider physician choice for patients.

The Justice Department requested more specific information from the AMA, which, on Jan. 22, sent 14 pages of analysis to investigators. The AMA report included an examination of Aetna's contracting practices. According to the AMA report, "Aetna seeks to use its market position to require physicians who may wish to participate in a PPO product, for example, to participate in an HMO – a substantially different product – even if they have ethical or quality objections, and even if the practice is not in a position to accept the substantial insurance risk involved in HMO products . . ."

Short of legislation and/or federal edicts, many physicians wonder how they can protect themselves from all-products clauses. Rust said that while "there is no magic bullet, I believe all answers come down to physicians integrating into larger groups." He explained that integrated physicians groups, different from physician networks, are a legal and effective antidote to all-products clauses. By integrating and submitting all billing to payers using a single FIN number, physicians have an all-or-nothing threat of their own.

According to Rust, unlike a network, in which the payer still negotiates with physicians individually, a fully integrated physicians' group negotiates as a bloc. It's a situation, Rust said, that carries clout. "Aetna will start to negotiate then," he predicted.

Dr. Morris, the physician who stopped seeing HMO patients, believes he took the path most appropriate to physicians faced with take-it-or-leave-it tactics: just say no. Acknowledging it's a frightening prospect for some, Dr. Morris wants other physicians to know his practice "has done just fine" since deciding to go it alone. ■

Tying relief sought

Legislative activity is under way to make health plan product tying illegal. Supported by ISMS, H.B. 1265, sponsored by Rep. Kurt Granberg (D-Centralia), and S.B. 440, sponsored by Sen. Dan Cronin (R-Elmhurst), make it unreasonable restraint of trade for a health insurance company to require a physician to participate in all of its plans in order to participate in one or a limited number.

IMPAC Annual Meeting slated

The Annual Meeting of the Illinois State Medical Society Political Action Committee will be held April 23 in Oak Brook. All IMPAC members are encouraged to attend. The meeting will begin immediately following recess of the ISMS House of Delegates opening session of the ISMS Annual Meeting to be held April 23-25.

Both meetings will be held at the Oak Brook Hills Resort & Conference Center, 3500 Midwest Rd. For more information, call (800) 782-ISMS.

And they're off ...

(Continued from page 1)

There is one major difference, however: The Flowers bill holds health insurance carriers liable for harm to an enrollee that is caused by health care plan treatment decisions.

ISMS supports both bills, but opted to leave out the liability provision from H.B. 579 to avoid almost certain defeat in the Senate, said Nestor Ramirez, MD, chairman of the ISMS Governmental Affairs Council. Similar provisions in earlier bills could never withstand opponents' fierce challenges, he explained. In fact, the Illinois Association of Health Maintenance Organizations has helped crush previous patient rights bills. Again this year, IAHMO has made a preemptive strike by introducing its own Managed Care Reform Act, S.B. 332, sponsored by Sen. Dave Syverson (R-Rockford), and H.B. 1277, sponsored by Rep. Rick Winkel (R-Champaign).

Some legislators leading the patient rights movement in the General Assembly agree that the Flowers bill might be doomed. "I don't think H.B. 626 has a chance at all," said Rep. Gwenn Klingler (R-Springfield), who is an ardent supporter of patient rights legislation. She noted that a similar attempt at compromise on H.B. 626 failed last year, so she co-sponsored H.B. 579 in the hope that the bipartisan desire for health plan reform would result in adoption of legislation that Republicans and Democrats alike would embrace.

"H.B. 579 is bipartisan and designed to strike the necessary balance that protects patient and physician rights while ensuring the viability of HMOs," said Rep. Jeffrey Schoenberg (D-Wilmette), who is one of the bill's chief co-sponsors.

Although Flowers said she is open to negotiation on H.B. 626, she doesn't foresee compromising on the liability provision. "I don't know where I can give on that issue because the other health care entities – such as physicians, nurses, pharmaceutical companies and equipment makers – are held responsible for their actions," Flowers said. "Why are we trying to protect insurance companies?"

Gov. George Ryan set the stage for health plan reform in his State of the State speech Feb. 17 by urging legislators to reach across the aisle and compromise. "I know that there are strong beliefs on this issue – and I also believe there is a consensus that we must reform this system. It's a problem we must address together this session," he said.

The timing is politically correct to pass managed care reform, observers note. "Many legislators who did not support last year's Managed Care Patient Rights Act talked in their campaigns about how important managed care reform was," said Klingler. "They really can't back off from their pledge now." ■

H.B. 579 sponsors

Five principal sponsors:

Rep. Jeffrey Schoenberg (D-Wilmette)
Rep. Ralph Capparelli (D-Chicago)
Rep. Carolyn Krause (R-Mt. Prospect)
Rep. Gwenn Klingler (R-Springfield)
Rep. Sara Feigenholtz (D-Chicago)

Co-sponsors:

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David Winters (R-Rockford)
David Wirsing (R-DeKalb)
Kay Wojcik (R-Schaumburg)
Anne Zickus (R-Palos Hills)

Physicians are urged to call, fax or e-mail their state representative today to voice support for H.B. 579. If your state representative is a co-sponsor, thank him or her. If not, ask your lawmaker to sign on as a supporter of H.B. 579.

If you don't know who represents you in the Illinois General Assembly, call (800) 782-ISMS, or send an e-mail request to govt@isms.org.

Med students get lesson in government

A group of students from Southern Illinois University School of Medicine recently took time out from medical studies to contemplate how they can impact the legislative process. Members of the school's newly formed Political Action Committee toured the Illinois Capitol in Springfield and met with Rep. Gwenn Klingler (R-Springfield) (fourth from left).

The group's goal is to explore ways that physicians can bring about change in health policy, said its founder Kimberly Doody (fourth from right).

The students intend to champion bills submitted by ISMS, understand how a bill becomes a law and give voice to their own perspective as future medical professionals. Doody said she formed the committee as an offshoot of the AMA student section at SIU. Pictured with Rep. Klingler and Doody are students (from left) Peter Rao, Todd Smith, Jill Weber, Seth Stamberger, Joe Lachica, Jim Young and Greg Schmieder.

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Illinois Medicine

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Hepatitis C look-back: What physicians need to know.

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Physician tells delayed-billing woes. Springfield Update

PAGE 3

Patient rights showdown at the Capitol

Photos by Ron Ackerman

Siding with the Illinois Association of Health Maintenance Organizations, representatives of the Illinois Academy of Family Physicians urge a House committee not to pass ISMS-supported patient rights legislation. Vincent Keenan, IAFP executive vice president (left), Ron Johnson, MD, IAFP board member (center), and Robert Burger, IAHMO executive director, testified before the Health Care Availability and Access Committee March 2.

Legislators grapple with divergent bills

BY PAULA KRAPF

[SPRINGFIELD] A patient rights legislation face-off looms large over the General Assembly, where the House and Senate are expected to support different health plan reform bills.

The ISMS-initiated patient rights bill, S.B. 579, scored a victory when it was passed out of the Senate Insurance and Pensions Committee and moved to the full Senate. Jane Jackman, MD, a Springfield family physician and ISMS immediate past-president, testified in support of the bill. A second patient rights bill, S.B. 626, was defeated in the Senate committee.

The opposite outcome was true in the Democratic-controlled House, where H.B. 626 passed the committee level and moved to the floor and H.B. 579 did not.

The two bills differ on one fundamental topic: Both the Senate and House versions of 626 allow consumers to sue their managed care plans; the Senate and House versions of 579 do not. Each bill enjoys bipartisan support in several areas, such as a ban on gag clauses, increased access to specialists, emergency room access without preauthorization, a ban on transfer of liability and utilization review that employs national standards.

Sen. Tom Walsh (R-Westchester), one of S.B. 579's chief sponsors, predicted the House

(See Showdown, page 10)

ISMS President Richard Geline, MD, testifies before a House committee in favor of a comprehensive patient rights bill initiated by the Society and a second one sponsored by Rep. Mary Flowers (right).

IAFP sides with HMOs, opposes patient rights

ISMS leaders expressed disappointment and sadness in the wake of the Illinois Academy of Family Physicians' surprise statehouse ambush during recent legislative hearings on health plan reform.

During a hearing before the Health Care Availability and Access Committee on March 2 in Springfield, IAFP stunned

(See IAFP, page 10)

Fraud rally targets physicians

BY PAULA KRAPF

See related editorial, President's letter...Page 4

[CHICAGO] The prospect of an army of senior citizens equipped with magnifying glasses questioning each line item on their medical bills fills Peoria dermatologist Chester Danehower, MD, with considerable dismay.

He has no problem responding to patients' billing queries, but he vehemently objects to the federal government's attempt to recruit the nation's 39 million Medicare beneficiaries to weed out fraud – especially when inadvertent errors such as coding mistakes are included in what is defined as fraud.

"This is a witch hunt that makes doctors look like the enemy to their patients," Dr. Danehower said. "It erodes patients' trust in their physicians." Physicians in Illinois and across the nation are braced for patient skepticism about their billing honesty following a Feb. 24 national rally to stir up interest in the Medicare "fraud fighters" program. The campaign is a collaboration between the federal government and the 32 million members of the American Association of Retired Persons to eliminate Medicare waste, fraud and abuse. The public outreach campaign, featuring the slogan "Who Pays?

(See Fraud rally, page 10)

Markus Giolas

Scores of senior citizens rev up to answer a call by the federal government to report suspected Medicare overcharges at a Chicago rally held Feb. 24.

Ryan rallying cry: *Health plan reform, now*

BY PAULA KRAPF

[CHICAGO] Patient rights take precedence over profits, and the managed care system must be – and will be – reformed, said Gov. George Ryan, who served up a palate-pleasing menu of health care initiatives at the Chicago Medical Society's 1999 Midwest Clinical Conference. Ryan was the keynote speaker at the event's luncheon held Feb. 26 at Navy Pier.

"Managed care reform is one of the high priority issues in the Illinois General Assembly, and I think this spring we can get the job done," he said. The governor said he will call on ISMS and other medical practitioners as well

(See Ryan, page 10)

Andrew Corrigan Halpern

Prior to presenting the keynote address, Gov. George Ryan (left) speaks with ISMS trustee M. LeRoy Sprang, MD, a Chicago-area Ob-Gyn, at the Chicago Medical Society's 150th Anniversary Midwest Clinical Conference held at Navy Pier Feb. 26.

INSIDE

Changes in the works for end-of-life care

BY JEFF BLACK

[CHICAGO] If a growing segment of organized medicine prevails, how physicians view and deal with issues surrounding palliative and end-of-life care – even death itself – will change. Some experts say what's needed is nothing short of a cultural metamorphosis. A recent conference in Chicago may have signaled the beginning of an educational process key to that shift.

"Education for Physicians on End-of-Life Care" was a three-day conference sponsored by the American Medical Association and the Robert Wood Johnson Foundation, with the support of the Illinois State Medical Society. The third of four regional gatherings, the conference, held March 5-7, drew nearly 70 physicians from Illinois and nationwide.

In all sessions, physician-trainers revealed practical strategies and advice for dealing with terminal patients whose greatest hope in their final days, polls show, is not to be abandoned without guidance, help or pain relief.

Linda Emanuel, MD, AMA vice president for ethics standards and EPEC principal investigator, said too many physicians still see a patient's death as a personal failure. "We live in a death-denying culture," she stated. "We fight against death at all costs. Death is the enemy." Additionally, given uncomfortable emotions created by end-of-life issues, and the pressure to face their own mortality, Dr. Emanuel found it little wonder that physicians, despite good intentions, often fail to provide effective, supportive care.

Dr. Emanuel emphasized the importance of communication skills in the physician-patient equation. "For years, the medical field has self-selected for men and women who can deal with vast amounts of technical knowledge – to the exclusion, I'm afraid, of those who can communicate that knowledge effectively. But it's communication skills that bring the whole thing together." The situation, she said, must change.

The conference was designed to train physicians and others to return to their hospitals or practices as mentors to train colleagues, organizers said. Dr. Emanuel praised the "missionary spirit" of the national experts, local champions and program directors brought together by the "training the trainer" conference.

Jane Jackman, MD, ISMS immediate past president and an enthusiastic EPEC advocate, said the program is needed because most physicians never received end-of-life training. "I graduated from medical school totally unprepared to tell patients they were dying, or to break the news to a family that a loved one had died."

Dr. Jackman views an increased emphasis on end-of-life training as a natural outgrowth of the Society's major purpose: to improve the quality of medicine in the state. Improved end-of-life skills, she added, will also help end the call for physician-assisted suicide, a practice ISMS opposes. "We have wonderful hospices in Illinois," Dr. Jackman said. "If physicians improve their skills, there will be no reason for physician-assisted suicide."

Damon Marquis, EPEC conference project manager, said organizers would be thrilled if state societies provided similar programs for their own members. Some state societies, he said, including Texas and Hawaii, already use EPEC in their training. Hawaii's organization publicly embraced EPEC as an alternative when opposing physician-assisted suicide legislation.

The conference curriculum comprised four general plenary sessions – "Gaps in End-of-Life Care," "Legal Misconceptions in End-of-Life Care," "Elements of End-of-Life Care" and "Next Steps" – as well as 12 small-group modules. Module topics included communicating bad news, pain management, withholding/withdrawing treatment, and last hours of living.

Marquis was quick to note that a goal of EPEC training is not to make palliative care specialists of every physician. "Our feedback suggests physicians are hungry for even the most basic information."

Dr. Emanuel acknowledged changing the medical status quo is a major undertaking. "But it's what we're aiming for," she affirmed. "I think all the pieces of the puzzle are finally coming together." ■

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The check may be getting closer to the mail

Legislation would compel carriers to pay their bills on time

BY PAULA KRAPF

[SPRINGFIELD] With an ocean of bills to pay, but only a puddle of invoice payments trickling into his Libertyville practice, anesthesiologist Bruce Irwin, MD, recently was forced to procure a loan in order to meet the payroll, rent and other expenses for the Center for Pain Control he owns.

The center, which employs five other physicians, is in this bind because many insurers with whom the center contracts take up to 57 days to pay claims, Dr. Irwin told the Illinois House Insurance Committee. He testified March 2 in support of an ISMS-supported bill to require insurers to make timely claims payments.

"Approximately 40 percent of the business's accounts receivables are outstanding," he said.

Sponsored by Rep. Andrea Moore (R-Libertyville), H.B. 2182 would require insurers to pay claims for health care services within 30 days of receipt of a clean claim; capitation payments would be due within 45 days after an enrollee selects a physician. Claims not paid after the time limit would be assessed a penalty of 9 percent per annum.

Dr. Irwin told the committee his business often is forced to resubmit bills three or four times because insurance carriers lose information, even though it was stapled to the original form. An unscientific survey he conducted of several physicians practicing in his region revealed that delayed payment practices are rampant, Dr. Irwin added.

ISMS President Richard Geline, MD, also testified in support of the bill, pointing out that more than 30 states have tackled delayed payments by enacting legislation that mandates timely payment of claims by insurers for services rendered by physicians and other health care providers.

"Under these circumstances, physicians and hospitals are essentially providing health insurance carriers with an unapproved interest-free loan. [Princeton University health care economist] Uwe Reinhardt found that some carriers could earn up to $400,000 a day on withheld funds," Dr. Geline said.

To increase awareness of this pervasive payment problem, ISMS is asking physicians to report incidents to the Society at (800) 782-4767 and to the Illinois Department of Insurance at (217) 782-4515.

Other proponents of the bill include the Illinois Hospital and HealthSystems Association. Opponents, who question the need for and the intent of this bill, include the Illinois Life Insurance Council and the Illinois Association of Health Maintenance Organizations.

H.B. 2182 is slated for further discussion in the Insurance Committee before the committee votes on whether to pass the bill to the full House. ■

Photos by Ron Ackerman

"I had to take out a loan to meet the payroll."

– Bruce Irwin, MD, anesthesiologist and owner of the Center for Pain Control, explained the financial hardship physicians face when claims payments trickle in late.

ISMS President Richard Geline, MD, testifies March 2 in Springfield before the House Insurance Committee on a bill sponsored by Rep. Andrea Moore (right) that would require insurers to make timely claims payments.

Legislators ponder host of health care proposals

BY PAULA KRAPF

A proposal to prohibit insurers from denying payment for medically necessary inpatient admissions and related services simply because the patient or physician has unsuccessfully attempted to notify the payer is pending before the House Health Care Availability and Access Committee. H.B. 1118 is sponsored by Rep. Edgar Lopez (D-Chicago). A similar provision is included in the ISMS comprehensive patient rights legislation.

The status of other ISMS-endorsed bills is as follows:

➥ **Unfair insurance practices.** H.B. 1265, sponsored by Rep. Kurt Granberg (D-Centralia), and S.B. 440, sponsored by Sen. Dan Cronin (R-Elmhurst), would make it an unreasonable restraint of trade for a health insurance company to require a physician to participate in all of its plans in order to participate in one or a limited number. **Status:** H.B. 1265 approved in committee; now before the full House; S.B. 440, Senate Insurance Committee.

➥ **Health care professional credentialing act.** H.B. 1780, sponsored by Rep. Angelo "Skip" Saviano (R-River Grove), chairman of the House Registration and Regulation Committee, would require the Illinois Department of Public Health to develop standardized credentials verification to provide organizations wanting to credential a physician with his or her core credentials data. **Status:** Approved in committee; now before the full House.

➥ **Hospital peer review good faith immunity.** H.B. 2303, sponsored by Rep. Jay Hoffman (D-Collinsville), would make a hospital, its employees and staff members involved in peer review liable for civil damages only in the event of wilful or wanton misconduct. Current law provides absolute immunity. **Status:** Approved in committee; now before the full House.

➥ **Medical staff privileges denial notice.** S.B. 953, sponsored by Sen. James Rea (D-Christopher), would include pre-applicants and those requesting an application among persons entitled to privileges. Hospitals would be required to consult with the medical staff prior to closing membership in the entire or any portion of the medical staff or department. **Status:** Senate Public Health and Welfare Committee.

Legislative UPDATE

➥ **Definition of surgery.** H.B. 874, sponsored by Saviano, would amend the Medical Practice Act to define surgery because Illinois statute does not currently include a definition of surgery. **Status:** Approved in committee; now before the full House.

➥ **Death penalty/medical practice.** H.B. 926, sponsored by Rep. Tom Ryder (R-Jerseyville), and S.B. 1169, sponsored by Sen. Arthur Berman (D-Chicago), would ensure that the Department of Corrections could not request, require or allow licensed physicians to participate in an execution. **Status:** H.B. 926, House Judiciary I Committee; S.B. 1169, Senate Judiciary Committee.

➥ **Health care professional advertising.** H.B. 1441, sponsored by Saviano, would require all licensed health care providers to include the appropriate titles, such as MD, DO, OD and DC, in all advertising and promotional materials. **Status:** Approved in committee; now before the full House.

➥ **Helmet requirements.** The House Children and Youth Committee recently rejected the provision of ISMS-backed H.B. 802 that would require children to wear bicycle helmets. However, an amended version of the legislation requiring children to wear motorcycle helmets will advance to the full House for a vote.

➥ **Needle exchange program.** H.B. 298, sponsored by Rep. Sara Feigenholtz (D-Chicago), and S.B. 190, sponsored by Sen. Donne Trotter (D-Chicago), authorizes establishment of needle exchange programs and also would require appropriate education related to drug abuse. **Status:** H.B. 298 approved in committee; now before the full House; S.B. 190, Senate Public Health and Welfare Committee.

➥ **Physician and hospital liens – notice of settlement.** H.B. 2192, sponsored by Ryder, and S.B. 507, sponsored by Sen. Kirk Dillard (R-Downers Grove), would require that a physician be notified in writing prior to the satisfaction of a judgment, award or settlement. **Status:** H.B. 2192, House Rules Committee; S.B. 507, Senate Judiciary Committee.

➥ **Clinical privileges for certified registered nurse anesthetists.** H.B. 553, sponsored by Saviano, would license CRNAs similar to the licensing for advanced practice nurses that the General Assembly enacted last year. **Status:** Approved in committee; now before the full House.

➥ **Prohibition on restrictive covenants.** S.B. 925, sponsored by Sen. Carl Hawkinson (R-Galesburg), would prohibit physicians from participating in, offering or making any agreement that includes a restrictive covenant. **Status:** Senate Licensed Activities Committee.

➥ **Corporate practice of medicine.** H.B. 2143 is sponsored by Saviano. Among many other provisions, it would limit entities that employ physicians to: physicians, physician groups, physician corporations, voluntary health service plans, health maintenance organizations, hospitals and hospitals' affiliates. **Status:** House Judiciary I Committee.

ISMS was victorious in helping to defeat the following bills:

➥ **Medical practice profiles.** H.B. 255, sponsored by Rep. Mary Flowers (D-Chicago), would have required public release of individual profiles on persons licensed under the act, including criminal charges, disciplinary actions, hospital privilege revocations, and medical malpractice awards. **Status:** Defeated in House Consumer Protection Committee.

➥ **Physicians liability coverage.** H.B. 1624, sponsored by Rep. Michael Madigan (D-Chicago), would have required all physicians to maintain a minimum of $1 million in liability coverage. **Status:** Defeated in House Insurance Committee.

➥ **Birthing centers.** H.B. 1737, sponsored by Rep. Sonia Silva (D-Chicago), would have established requirements for location, services and standards for no more than 10 birth center alternative health care models in the state. **Status:** Defeated in House Health Care Availability and Access Committee. ■

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EDITORIAL

Anti-fraud campaign pits patient against physician

To gather foot soldiers in its latest effort to clean up Medicare fraud and abuse, the federal government has enlisted the help of volunteer senior citizens.

Along with giving them an arsenal of marketing gimmicks – T-shirts, baseball caps and magnifying glasses – the U.S. Department of Health and Human Services deputized members of the American Association of Retired Persons; their mission is to turn in doctors who may be overcharging Medicare.

Sounds simple enough. And if the fraud and abuse dilemma estimated to cost $12.6 billion annually could be contained by fingering the bad guys who bill twice for one service, then the new plan just might work. Unfortunately, the Medicare monster is not so easily controlled as the new, oversimplified Who Pays? You Pay campaign would like taxpayers to believe.

Medicare regulations constitute 100,000 pages of confusing and arcane rules, which leave health care providers drowning in a sea of red tape. The confusion lies in the Health Care Financing Administration's failure to properly distinguish between genuine fraud and billing mistakes.

HCFA, which oversees Medicare, has constantly lumped together a wide assortment of issues arising from claims, including documentation deficiencies, coding mistakes and criminal fraud. For two years, the American Medical Association has repeatedly but unsuccessfully sought to obtain documents explaining how the Office of Inspector General has alluded to the magnitude of improper billing.

What the government has failed to accomplish, it now supposes will be achieved by training a regiment of AARP recruits courtesy of a 10-minute "training" video and access to a toll-free hotline.

In parading the seniors before the media, HHS demonstrated it is capable of showbiz antics and headline glomming. But in all the excitement, HHS apparently forgot how crucial a strong bond of trust between physicians and patients is to good medical care. How sad that the government has set up a situation where a patient would discuss serious health concerns with a physician and then return home to report him or her to a fraud and abuse hotline.

Fortunately, this campaign is likely to be ineffective. It would take more than a publicity stunt to undermine a solid connection between a doctor and a patient.

The department should reevaluate its efforts. Instead of baiting the AARP volunteers into becoming detectives intent on investigating their physicians, perhaps it should expend its energy inward to devise a system to better distinguish between real fraud and honest mistakes. Let the senior citizens of this country concentrate on their health care without the government injecting the suggestion that all physicians cannot be trusted.

PRESIDENT'S LETTER

Evidence mounts: Medicare ship tilting from quality to penalty

Richard A. Geline, MD

The Clinton administration seems to be . . . placing more emphasis on finances and penalties.

Two recent announcements from Washington, D.C., raise concerns that Medicare leadership is more interested in collecting penalties for billing errors than in monitoring and improving the quality of health care its recipients receive.

On Feb. 24, the U.S. Department of Health and Human Services and the American Association of Retired Persons announced a new joint program. It was described as an effort to engage Medicare beneficiaries and their families in a discussion with the administration about efforts to address waste, fraud and abuse.

But what the program really amounts to is unofficially deputizing senior citizens as agents of the government by encouraging them – with up to $1,000 bounties – to report suspect bills to the Office of Inspector General's hotline.

Trumpeting the event, the AARP circulated a pamphlet to its members inaccurately stating that as much as 10 percent of Medicare charges are fraudulent. However, a recent report from the OIG itself claims a significantly lower percentage of improper payments.

The American Medical Association, through President Nancy Dickey, MD, responded promptly and vigorously, writing in The Wall Street Journal, "The effort is dangerously flawed, for the government doesn't know what the degree of Medicare fraud really is, nor does it acknowledge that government itself is a big part of the problem."

Although some newspapers published my letter to the editor on this issue, the media overall have reacted with a great yawn.

Another troubling concern springs from a proposed new direction for Professional Review Organizations, which the Health Care Financing Administration established to promote quality health care services for Medicare beneficiaries and to determine if services rendered are medically necessary, appropriate and meet professionally recognized standards of care.

During the early 1980s, the focus was on utilization review and payments. An objectionable "point system" was developed that could have resulted in some hospitals being separated from Medicare. Complaints that these efforts ignored quality matters were widespread at the time.

In 1993 under the Fourth Scope of Work, and in 1996 under the Fifth Scope of Work (actually a three-year contract), the government's emphasis turned to quality. The medical community responded with an increased level of collaboration among PROs, hospitals and physicians. Hospital complaints regarding PRO review decreased dramatically and the AMA House of Delegates witnessed a corresponding decrease in resolutions dealing with the issue.

The recently released draft of the Sixth Scope of Work includes something called the Payment Error Prevention Program, developed to address what is perceived as an intolerably high amount of money paid for incorrect bills. Under the PEPP, PROs will be required to develop projects that monitor the accuracy of Medicare payments.

During the first year of the contract, the PRO must conduct a review and intervention program in two specific areas: unnecessary admissions and upcoded DRG assignments.

An incentive program and performance-based service contract will be incorporated in the stepped-up operation. *Most ominously, PROs are asked to establish contact and coordination with state and federal agencies responsible for law enforcement activities that relate to the Medicare program.*

Any way one looks at these events, the conclusion seems the same: The Clinton administration is stepping away from an educational approach focusing on quality, to placing more emphasis on finances and penalties.

Physicians should be alarmed that the traditional physician-patient relationship is being jeapordized. The AMA and ISMS are responding to these ongoing affairs, once again showing the value of membership.

GUEST EDITORIAL

That's MD, not HP!

By Rodney C. Osborn, MD

As we all know, the MD attached to the byline on this editorial stands for Medical Doctor, but there are more than a few forces outside the realm of professional medicine that would like to see MD replaced with HP: Healthcare Provider.

A term gaining increasing popularity among government agencies, third-party payers and the media, "health care provider" is creeping into common parlance, enveloping specific professional designations. This is no small concern.

I was among several delegates of the Peoria Medical Society who recently introduced a resolution to ISMS that this term be recognized as inadequate to describe a physician's individual qualifications, and support instead specific terms such as "doctor," "physician," "MD" and "DO."

We went so far as to suggest submission of a similar resolution to the AMA, encouraging elimination of any reference to one who attained an MD or DO degree as merely a "health care provider."

Hair-splitting? Hardly. The training and responsibilities shouldered by any medical professional are inherently specific, and a title is an immediate indicator of education and authority, whether for a physician, surgeon, nurse or nurse's aide. A watered-down universal term blurs the distinction in education, preparation and training that is often vital to patients' understanding of who is taking care of them.

Patient well-being is at the core of our concern. The infusion of business concepts and precepts in health care has done much to detract from the doctor-patient relationship, now going so far as to change how we name it on a daily basis; it is, in short, quickly becoming the health care provider-client relationship. This means that anyone in contact with the patient has the potential to fit the "provider" classification – whether or not he or she is an actual physician.

Ironically, the resulting confusion often demonstrates how important accurate titles are to a patient. Suppose a surgeon/specialist employs a nurse and a physician's assistant. Although the surgeon does in fact perform the surgery, he or she may not have any preoperative patient contact and doesn't necessarily participate in the workup or postoperative in-house care.

But when the patient wants to discuss the outcome of the surgery, he or she is bound to ask, "When will I see my doctor?" Don't expect to hear, "I need to see my health care provider." Even though patients are being bombarded with the all-purpose "provider" label, they recognize the differences.

The generalizing of titles is symptomatic of the business world's efforts, under the guise of holding down costs, to pass responsibility for essential patient services to lesser-trained individuals. In New York state, hospitals cut back on physician credentialing in favor of nurse credentialing, presenting patients with an option to have either a doctor or a nurse attend to their health needs. The implication is that the two are equivalent, negating the entire body of knowledge physicians bring to the physician-patient relationship.

To thwart this movement on our patients' behalf, physicians must demand use of proper titles for every medical professional. It is a truth-in-advertising issue, and as physicians, we should not allow our insight, education and training to be subjugated by a generic title that demeans our expertise and undermines patient trust.

Rodney C. Osborn, MD, a Peoria anesthesiologist, is a member of the ISMS Board of Trustees.

. . . "This patient refers to me as an on-call-o-gist . . ."

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ISMIE Update

Coming soon: Heeding the drug warnings

What physicians should know about the hepatitis C look-back

The search for patients who received tainted blood.

BY JOY LE VEE

A massive national search to identify, find and notify about 570,000 Americans who may have received blood from donors who later tested positive for the hepatitis C virus is under way.

Although the physicians' role in patient notification of potential victims appears to be reduced from earlier proposals, the "targeted look-back" campaign will likely heighten the need for doctors to be well prepared for follow-up treatment of newly revealed cases.

The campaign is hunting for people who received blood during the years 1987 to 1992. Since 1992, a screening test capable of detecting about 97 percent of HCV infections has all but eliminated transfusion as a source of transmission.

According to a time line established by the Food and Drug Administration, blood centers should have provided hospitals with a list of recipients by March 23. Hospitals and/or physicians now have up to one year to notify patients that they need to be tested for HCV.

Although the FDA's initial plan called for the physician involved in a patient's care at the time of the transfusion to make the notification, final guidelines announced in September give hospitals the option of making the primary contact themselves.

At a hepatitis C look-back risk management workshop held Feb. 20 in Washington, D.C., by the American Association of Blood Banks, it was reported that most hospitals are preparing to make their own notifications, and that hospitals and/or blood centers expect to do most testing of notification recipients.

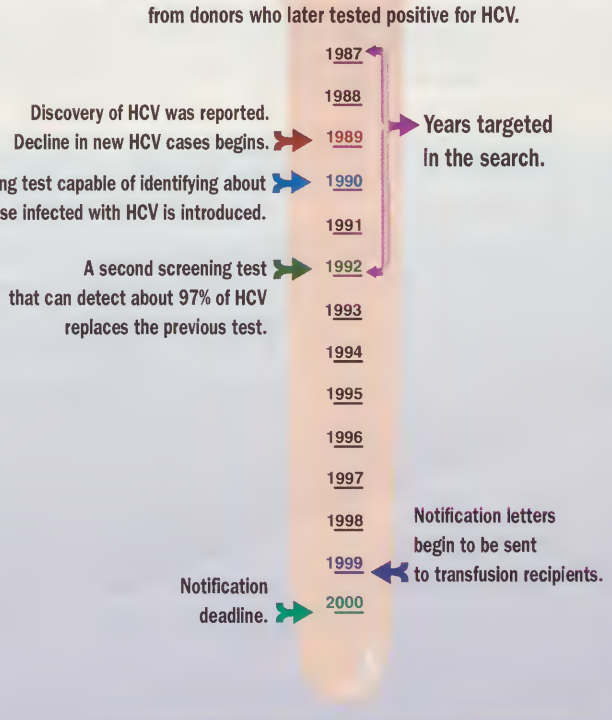
Plans are for patients who test positive to be referred to gastroenterologists who have training and experience with HCV and other hepatitis viruses.

One concern discussed at the workshop is that primary care physicians generally have a low level of awareness about the growing risks of HCV and about the look-back program, and therefore may not be best suited for making the notification, said Louis Katz, MD, a member of the Interagency Task Force on HCV Lookback (coordinated by the American Association of Blood Banks), and medical director of the Mississippi Valley Regional Blood Center, which supplies blood to hospitals in western Illinois and eastern Iowa.

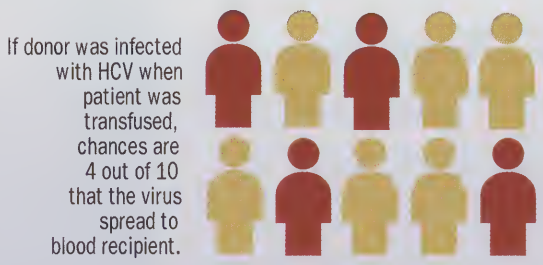
(Continued on next page)

Look-back initiative

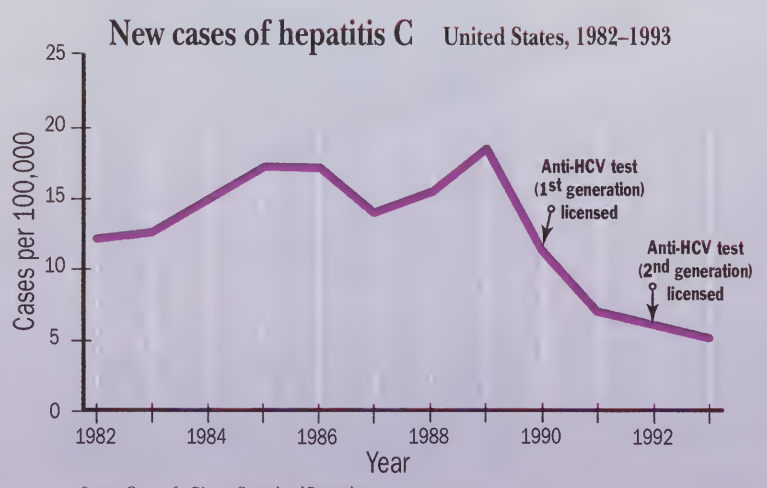
Searching for people who received blood between 1987 and 1992 from donors who later tested positive for HCV.



Patient risk



New cases of hepatitis C United States, 1982–1993



Source: Centers for Disease Control and Prevention

Physicians who are responsible for notifying patients of possible exposure should:

- ✓ Inform the referring hospital of each attempt at notification.
- ✓ Personalize notification letters, and provide detailed information regarding the possible infection.
- ✓ Arrange for patients to receive counseling during and after testing.

Preventing lawsuits

When 15,000 transfused patients were notified several years ago of possible exposure to HIV, 3,000 lawsuits resulted, about 50 percent involving physicians.

Risk management experts predict that a look-back currently under way searching for about 570,000 Americans who may have received blood from donors who later tested positive for the hepatitis C virus could inspire three or four times as many lawsuits as the HIV notification.

"There are many more people potentially infected with hepatitis C," explained Lori Bartholomew, director of loss prevention and research for the Physician Insurers Association of America, an association of medical professional liability insurers, of which ISMIE is a member.

By March 23, blood centers were to have provided hospitals a list of people who could have received tainted blood during the years 1987 to 1992. Hospitals and/or physicians have one year to notify patients that they need to be tested for HCV.

Lawsuits deriving from the look-back could target physicians treating at the time of the transfusion with such allegations as: the transfusion was not indicated, alternative treatment was not discussed or the physician failed to warn the patient that he or she could acquire hepatitis C from the blood. Another area of potential exposure is failure to diagnose HCV in new or existing patients.

To protect against a repeat of the HIV look-back

(Continued on next page)

Hepatitis C

(Continued from previous page)

"Hospital notification improves the likelihood of sending out a more consistent, thoughtful and appropriate message to patients, because not all physicians are sufficiently knowledgeable about HCV," Dr. Katz said.

Concerns also exist regarding the ability of hospitals to identify the physician who ordered the transfusion, and whether that physician is the best person to make the notification, Dr. Katz said.

"There can be a long and winding road from the blood order to the physician, and hospitals may not have a clear record of who ordered the transfusion," he said. "The physician in charge of the patient's care at the time of the transfusion may be a surgeon, anesthesiologist or other specialist who had only a brief relationship with the patient. In other cases, physicians may have had a long-term relationship with the patients, and could better provide personal reassurance and counseling. But in our mobile society, many of these relationships may no longer exist."

Although it now appears that primary care physicians are less likely to be involved in patient notification, Dr. Katz urged that they become well informed in order to provide appropriate medical attention to patients affected by the look-back.

The American Medical Association has launched a drive to educate physicians about the look-back program and HCV, according to Yank Coble, MD, a member of the AMA Board of Trustees and past chairman of its Council on Scientific Affairs. "We can tell from the number of hits on our Web site that physicians are taking advantage of our information," he said.

According to the Centers for Disease Control and Prevention, about four million Americans have been infected with HCV, of which three million remain chronically infected. About seven percent might have been infected by blood transfusions.

Other methods of transmission include intranasal exposure caused by cocaine use, injection of street drugs, accidental needlestick injuries, maternal-fetal transmission, and exchange of bodily fluids. In about 40 percent of cases, the method of transmission is unknown.

HCV causes an estimated 8,000 to 10,000 deaths annually, and the mortality rate could triple in the next two decades, said Miriam Alter, Ph.D., chief of the CDC's epidemiology section, hepatitis branch. The look-back is expected to identify an estimated 24,000 new HCV infections, and about 2,600 patients are likely to benefit from treatment.

"HCV infection is a major public health problem in the United States, and we need to implement programs to reach people who are already infected so they receive proper treatment, to reduce the risk of their developing severe liver disease, or dying," Dr. Alter said.

Questions have been raised as to whether the look-back program is the best use of health care resources, as detailed in an editorial published in the February issue of Transfusion.

"The low probability that a transfusion recipient is alive, traceable, and desirous of testing is striking," the editorial stated. "Identification of HCV infection in this cohort of patients may not be readily translatable into health improvements or greater longevity for them . . . . Will this public health effort accrue benefit commensurate with the hundreds of person-years of effort and the hundreds of millions of dollars of health care resources it will consume?"

The CDC will be evaluating the notification program and its associated costs, Dr. Alter said, and using the results of the survey to help make decisions about future notification programs.

Patient education pamphlets and other materials are available from the following sources:

- American Association of Blood Banks
  (301) 907-6977
  www.aabb.org
- American Liver Foundation
  (800) 465-4837
  www.liverfoundation.org
- Centers for Disease Control and Prevention
  (888) 443-7232
  www.cdc.gov/ncidod/diseases/hepatitis ■

Preventing lawsuits

(Continued from previous page)

outcome, physicians should be proactive in patient care, Bartholomew advised. "Physicians should routinely ask new and existing patients whether they have been transfused in the past 8 to 10 years so they can be tested," Bartholomew recommended. For those who test positive, suggest that family members be tested, she added. "Make sure that nobody falls through the cracks."

Brian Rocca, an attorney with Fedota, Childers & Rocca, a Chicago law firm that specializes in medical malpractice defense, urges physicians to become informed about the HCV look-back as quickly and thoroughly as possible.

Although it now appears that hospitals will do the majority of the notifications, in some cases the job will fall to the physician treating at the time of the transfusion. Physicians who contact transfusion recipients should personalize their notification letters, provide detailed information regarding the possible infection and arrange for patients to receive counseling during and after testing, Bartholomew said.

"The goal is to alleviate a patient's fears and minimize any anger that may be focused on the physician, and thereby reduce the likelihood of a lawsuit," she said.

Document everything in the patient record, and notify the referring hospital of each attempt at notification and of the outcome, she said. "Err on the side of caution."

Notification attempts should be thorough and documented, Rocca agreed. "If there is no response to your first letter, then send a certified letter, and after that try to get a phone number. The more efforts that you make, the stronger your defense in case of a lawsuit."

Failure to obtain informed consent before testing and breach of patient confidentiality may also become liability risks in this issue, Rocca said. Physicians should consider handling HCV consent forms and test results with the same privacy measures as HIV patient information, he said.

MALPRACTICE ROUNDUP

New Jersey Supreme Court bars patient's informed consent claim

In July 1998, in Baird vs. American Medical Optics, et al., the Supreme Court of New Jersey examined the question of whether a patient may avoid the statute of limitations for medical malpractice by arguing that some aspect of her treatment was unknown to her until much later, thus allowing a "lack of informed consent" claim to be raised beyond the malpractice limitations period.

In 1983, Eleanor Baird underwent surgery for removal of a subcapsular cataract and implantation of an intraocular lens. At the time of Baird's surgery, the Food and Drug Administration had not approved the lens for general marketing to the public, but had granted an investigational device exemption. In a clinical investigation of such a device, the FDA requires that the consent of participating subjects be informed.

Following the surgery, Baird suffered vision problems, causing her to undergo several subsequent surgeries. Approximately six years later, Baird alleged that she learned the lens was experimental and that her cause of action for a lack of informed consent should not accrue until she had reason to know of this type of injury. Although she had signed a five-page consent form, the plaintiff claimed she could not recall signing it and that it had not been fully explained to her.

The defendants moved for summary judgment, which was granted. Upon appeal, however, that decision was reversed on the basis that the statute of limitations did not bar Baird's claim of lack of informed consent.

The case was then appealed to the New Jersey Supreme Court. The New Jersey statute of limitations governing actions for personal injury requires a plaintiff to commence an action within two years after the cause of action accrues. Although New Jersey law prevents the statute of limitations from running when injured parties are reasonably unaware they have been injured through the fault of another, the Court determined on appeal that the plaintiff was fully aware of her surgical injuries by 1985. As a result, the case against the physicians was dismissed.

Women's health grant available

Grant awards totaling approximately $775,000 will be available for Fiscal Year 2000 from the Illinois Department of Public Health to fund initiatives that address women's health concerns. The department's Office of Women's Health is offering two channels of funding, classified as either women's health initiative grants or osteoporosis prevention and awareness.

The women's health initiative grants are targeted toward public and professional education and outreach programs that focus on breast cancer, cardiovascular disease, domestic violence, menopause and mental health. The maximum available award is $50,000.

Osteoporosis prevention and awareness grants ranging from $5,000 to $50,000 will be awarded to selected proposed programs addressing professional and public education and clinical outcome research designed to improve women's health as it pertains to osteoporosis.

Eligible applicants include local health departments, not-for-profit entities and community agencies capable of conducting the proposed project, either directly or indirectly through subcontract. Only Illinois institutions and organizations are eligible. Applicants may submit more than one proposal; however, the same proposal may not be submitted under both grant categories. Proposals are due by 5 p.m., April 12. The funding period is July 1, 1999 through June 30, 2000.

To request a copy of the grant guidelines, contact the Illinois Department of Public Health, Office of Women's Health, 535 W. Jefferson St., Springfield, IL 62761; call (217)524-6088; or e-mail to mailus@idph.state.il.us. ■

Y worries? ISMS doing its part

Will calamity strike when countless computer clocks roll into the year 2000? No one knows. Nevertheless, ISMS can offer some reassurance about its own readiness.

After an intense, four-phase effort involving assessment, remediation, testing and solution implementation, ISMS computer systems are on schedule to be Y2K compliant by October 31, 1999.

The effort does not stop with ISMS systems, however. The Society also is leading a comprehensive effort to assess the Y2K status of its vendors and suppliers, taking every step to maximize complete compliance throughout every network.

Although the Society has made substantial progress internally in addressing the Year 2000 problem, this initiative cannot guarantee the Y2K compliance of third-party industries servicing the organization, such as telecommunications, banking, securities, transportation and utilities. ■

Infant mortality decline sets new state record

Illinois' infant mortality rate continued its downward trend in 1997, reaching a record low of 8.2 deaths for every 1,000 live births. The rate has dropped almost 30 percent since 1990.

"This means 600 more Illinois babies survived to their first birthday [in 1997] than in 1990," Gov. Jim Edgar said while announcing the rate last November. "We must continue to build on efforts to provide and encourage even better prenatal and infant care in Illinois, especially among families at the greatest risk, to ensure that this healthy trend continues."

The 1997 infant mortality rate bested the old record – 8.4 infant deaths for every 1,000 live births – set in 1996. In 1997, 1,476 infants died before their first birthday compared with 1,536 infants the year before. Chicago's infant mortality rate declined to 10.7 deaths per 1,000 births, from 10.8 in 1996, and the Downstate rate dropped to 7.2 in 1997 from 7.4 in 1996.

In 1997, infant mortality rates among African-American babies dropped 5 percent to 16.5 per 1,000 births in 1997, from 17.1 in 1996. Among white infants, the rate dropped to 6.2 in 1997 from 6.3 in 1996.

John Lumpkin, MD, director of the Illinois Department of Public Health, attributed the dropping rates to better prenatal education and care. "Illinois women today are more aware of the need for early and comprehensive prenatal care and proper nutrition," he said. ■

Physician HELPline

ISMS' 24-hour Physician HELPline is available to link impaired physicians and their families with helpful resources.

Contact the HELPline at (312) 580-2499.

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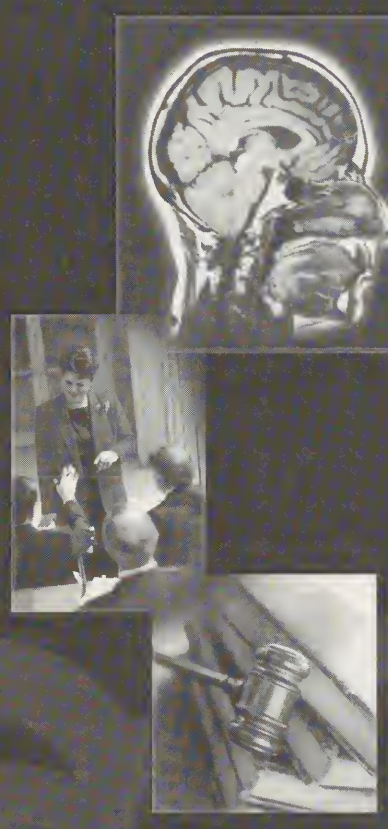

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Illinois Medicine is published every three weeks except biweekly in May and June; ad deadlines are four weeks prior to the issue requested. Although ISMS believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify ads at its discretion. Ads will be edited to conform to Illinois Medicine style.

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IAFP

(Continued from page 1)

ISMS by opposing H.B. 579, a patient rights bill endorsed by the Society and a wide range of consumer and physician organizations. In another surprising move, IAFP also testified in favor of an opposing bill sponsored by the insurance industry, including the Illinois Association of Health Maintenance Organizations.

Arthur Traugott, MD, chairman of the ISMS Board of Trustees, said the Society feels "great sadness" that IAFP is willing to jeopardize legislation that promises to make major headway in controlling the unchecked abuses patients and physicians face from the health insurance industry.

"In the Society's view, there is no acceptable reason for IAFP's decision to sign onto IAHMO's bills and/or oppose ISMS-backed legislation," Dr. Traugott stated in a March 8 letter to IAFP President Steven Wilk, MD. "It is especially troubling that these two IAFP developments occurred while our two organizations were amidst active negotiations to resolve our differences on such legislation, and ISMS was working in good faith to accommodate IAFP concerns."

Dr. Traugott noted that academy members were invited to serve on ISMS councils and committees; IAFP was invited several times to present its views to ISMS at various Society council and committee meetings; there were continued joint leadership meetings between representatives from both groups; and ISMS made repeated requests to IAFP for the academy's recommended language changes.

The IAFP action clearly indicates, Dr. Traugott stated in the letter, that the organizations have two very different perspectives on lobbying protocols. ISMS believes such protocols must be developed and mutually agreed to if IAFP desires to reopen discussion for future sessions of the General Assembly, he said. ■

Showdown

(Continued from page 1)

will compromise with the Senate and pass a patient rights bill for the greater gain. "A number of House members on both sides of the aisle realize that every day we stall, consumers are being hurt," said Walsh.

But some House Republicans fear that H.B. 626 will fail in the Senate because of its liability provision. Rep. Gwenn Klingler (R-Springfield) urged support of H.B. 579 instead so legislators can ensure that a patient rights bill becomes law.

"The Senate would be hard-pressed to not support H.B. 579, because they have supported similar legislation in the past," she observed.

Rep. Carolyn Krause (R-Mt. Prospect) said the liability clause does not belong in H.B. 626. "The courts are dealing with that issue," she said.

In a spirited defense of the bill, H.B. 626 sponsor Rep. Mary Flowers (D-Chicago) said, "If HMOs hire doctors and contract with hospitals and deny services, they should be held accountable."

Opponents also weighed in with their comments, including the Illinois Academy of Family Physicians (see accompanying story), insurers and business groups.

While ISMS backs both bills, the Society prefers the scope of H.B. 626, because of its health plan liability provision, said ISMS President Richard Geline. Testifying in favor of that bill before the House Health Care Availability and Access Committee March 2, Dr. Geline rebutted critics' claims that health plan reform would push managed care costs out of consumers' reach.

Citing the Congressional Budget Office's 1998 study on the cost of managed care reform, Dr. Geline said a patient rights bill would add only 4 percent to medical costs over a 10-year period. "That translates into pennies per day per patient, a cost well worth the great gains that can be achieved," he said.

A wide-ranging coalition comprising physician groups and health care practitioners, legal organizations, organized labor, women's and consumer advocacy groups have echoed ISMS' support for H.B. 626.

In light of the diverse viewpoints on health plan reform, Dr. Geline said all sides must define where they agree, determine what they can do now and decide what they should leave for another time. ■

Fraud rally

(Continued from page 1)

You Pay," educates senior citizens to recognize fraud and report suspected incidents to the federal government by calling a toll-free hotline. Successful prosecution would result in up to a $1,000 reward for the tipster.

Calling the campaign an "amazing display of dangerous silliness," ISMS and the AMA immediately protested that the program is "ill-focused, simplistic and threatens to drive a wedge" between doctors and their patients.

ISMS and the AMA noted that the federal government's broad definition of fraud and abuse lumps together genuine fraud, in which Medicare is billed for services not delivered, with honest mistakes over the proper interpretation of billing rules, such as coding differences and questions of medical necessity.

Organized medicine has been working for years with physicians and the government to put an end to intentional fraud, wrote Arthur Traugott, chairman of the ISMS Board of Trustees, and Randolph Smoak Jr., MD, the AMA's chairman, in a joint letter to members dated Feb. 26. These efforts include educating physicians about how to comply with Medicare's more than 100,000 pages of regulations; working with Congress to enact the necessary reforms to make the system work the way it should; and exposing and eliminating real fraud, wherever it occurs.

Opponents of the new Medicare crackdown also point out that efforts

Markus Giolas

The government's new Medicare anti-fraud campaign could turn into a witch hunt, said Joseph Lankford, vice president of business development for Chicago-based Mobile Doctors, at a rally to introduce the program.

under way to eradicate improper billing have already produced impressive results. The Office of Inspector General recently announced that the error rate for the $225 billion Medicare program has declined by nearly 45 percent in the past two years, from 14 percent in 1996 to 7.1 percent in 1998.

Physicians undoubtedly will be inundated with calls from patients who have signed on to the government's campaign, Dr. Traugott said. ISMS and the AMA suggest that doctors advise their patients that physicians share their desire to root out fraud, but that Medicare's rules are complex and can cause honest people to sometimes interpret them differently. Physicians should make it clear to patients that they are upset, too, because the more time they spend meeting bureaucratic requirements, the less time they have with patients.

Nancy-Ann Min DeParle, administrator of the Health Care Financing Administration, which oversees Medicare, responded to organized medicine that she recognizes the difficulty physicians face when trying to interpret Medicare regulations. The administration will work with state and national medical societies to implement a provider education program, she said. Details and the start date have yet to be determined.

The government considers doctors central to this new partnership, said Donna Shalala, secretary of the Department of Health and Human Services. "Most doctors and other health care professionals are honest. They want what we want: an honest system that pays honest providers for good-quality care," she said.

Still, Shalala's comments did not appease ISMS and the AMA. "We repeatedly have offered to sit down with Secretary Shalala to work out a serious and effective way to deal with documented cases of fraud," said Dr. Traugott. "Our offer still stands."

Physicians who have questions or want further details about the new program are encouraged to check the Society's Web site, www.isms.org, or call ISMS, (800) 782-4767. ■

Ryan

(Continued from page 1)

as consumer, business, labor and insurance groups to craft a law that all parties can support.

"Too often, managed care has interfered in the relationship between doctors and patients," Ryan said. His statement was interrupted by applause before he continued, "We have to make sure the managed care system is more interested in patients' health than the bottom line."

Ryan restated promises he made during his gubernatorial campaign to fight for a managed care reform law that includes such provisions as emergency treatment without barriers, timely notification of denial of care, a timely appeals process, choice of primary or specialty care physicians, a ban on gag rules and treatment decisions made by physicians, not insurers.

The governor also dished out an array of health care initiatives that focus on women, children, the uninsured and organ donations that include:

- Expanding prenatal coverage and ensuring that health insurance is affordable, accessible and portable. "We can't afford to ignore the 1.3 million people in the state who lack health care coverage," Ryan said.
- Extending the KidCare insurance program for low-income children. Ryan's recent edict to the Illinois Department of Public Aid called for reducing the bureaucratic red tape and increasing statewide awareness of KidCare.
- Building upon the Office of Women's Health so it can conduct more outreach, coordinate the work of state agencies that deal with women's issues and become a resource center for female employees.
- Widening efforts to promote organ and tissue donation so there are more referrals and actual donations. Although approximately 800 Illinois residents receive organ transplants each year, the waiting list has nearly doubled from five years ago, and 3,400 people now await an organ transplant, Ryan said.

"We will need the cooperation of the medical community and the Medical Society on these issues," he said. ■

Andrew Corrigan Halpern

Chicago pediatrician Billie Wright Adams, MD (center) visits with Chicago Medical Society President Janis Orlowski, MD, and Cardinal Francis E. George at CMS's recent Midwest Clinical Conference, where Dr. Adams received the 1999 Public Service Award.

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WHEN IT MATTERS MOST

:ORES LEGISLATIVE VICTORIES (PAGE 2)

Illinois Medicine

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Doctoring with the Internet

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The three e's of staying in touch with patients

PAGE 6

Stalemate or settlement?

Ron Ackerman

Sen. Thomas Walsh (right) speaks on the Senate floor March 25 in favor of the ISMS-backed patient rights bill he is sponsoring, as Matt Napierkowski, Republican staff member of the Insurance and Pensions Committee, looks on. S.B. 579 passed the Senate and has moved to the House for a vote.

Divergent patient rights bills sit before state House and Senate

BY PAULA KRAPF

NEWS ANALYSIS

The Illinois House and Senate have each laid a separate foundation for a patient rights law, and now the two chambers face the challenge of incorporating their disparate ideas into one sound structure. The question is whether or not the health plan reform impasse, which represents the different directions of the Republican-dominated Senate and the Democratic-controlled House, finally will be broken.

The two bills vying for support from the Legislature, H.B. 626 and S.B. 579, would give patients the right to:

- Access to specialty care.
- Care consistent with professional standards of practice to ensure quality nursing and medical practices.
- A choice of the participating physician responsible for coordinating care.
- Receipt of information concerning their condition and proposed treatment.
- Privacy and confidentiality of records.
- Utilization review programs consistent with highest national standards.

Legislators on both sides of the aisle say they believe the General Assembly can find common ground on S.B. 579. A majority of senators voted in favor of that bill March 25, and it has moved to the House for a vote. One day earlier that chamber passed H.B. 626, which then moved to the Senate. The key difference between the two bills is that H.B. 626 would allow patients to sue their HMOs; S.B.

(See Settlement, page 14)

FOLLOW-UP

INCENTIVES PLAN STILL ON HOLD

A controversial proposal to offer incentives to physicians who perform foot and ankle surgical procedures in their offices instead of hospitals and surgicenters remains on hold indefinitely as the plan's source, Blue Cross Blue Shield of Illinois, promises to seek input from ISMS and specialty societies regarding similar physician reimbursement initiatives it may undertake in the future.

Speaking to members of ISMS' Third Party Payment Processes Committee in March, Allan Korn, MD, the Blues' vice president and chief medical officer, said the Blues recognized ISMS' and specialty societies' concerns. The insurer will review its data before

(See BCBS, page 14)

"LIFE GOES ON"

Tougher drunken driving and seat belt laws have decreased traffic deaths in Illinois – to the extent that the state's organ donations dropped in 1998.

Therefore it is more important than ever that Illinois hospitals and health care providers refer all potential organ donors to their designated organ procurement organization, said Illinois Secretary of State Jesse White, whose department oversees the Illinois Organ/Tissue Donor program, "Life Goes On."

April 18-24 is National Organ and Tissue Donor Awareness Week, and White's office is currently distributing to hospitals an instructional video that examines the donation process from the perspective of physicians, critical care nurses, organ procurement staff and others.

The self-study program can be used in group settings and by individuals who want to earn one hour of continuing medical education credit. For more information, call the Secretary of State's organ donor program office at (217) 782-5120.

Medicaid investigation

IDPA survey finds most physicians filing accurate claims

BY PAULA KRAPF

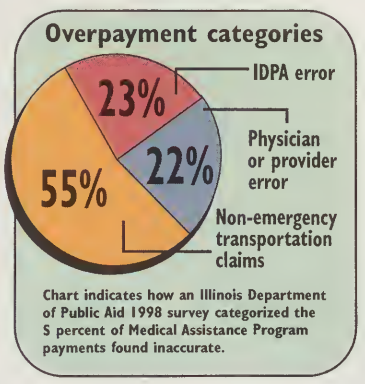

Chart indicates how an Illinois Department of Public Aid 1998 survey categorized the 5 percent of Medical Assistance Program payments found inaccurate.

[CHICAGO] The first full appraisal of a state's Medical Assistance Program conducted in the country revealed that Illinois has a 95 percent payment accuracy rate. Those results tell the Illinois Department of Public Aid that its MAP has a sound payment system, the majority of physicians and other providers are honest, and the agency's many pre- and post-payment reviews are effective, said Steven Bradley, chief of the agency's Bureau of Medical Quality Assurance.

Bradley presented the findings to a ISMS' Third Party Payment Processes Committee meeting held at the Society's Chicago headquarters in March. The $6 billion-a-year MAP serves 1.5 million Illinoisans who are on public aid or who do not qualify for aid but cannot afford medical care.

The Illinois accuracy rate is better than either of the two previously published payment accuracy rates for the Medicare program – particularly good news in light of the federal government's widely publicized Medicare fraud-fighting program that asks

(See Medicaid, page 10)

INSIDE

After 13 loooong years . . .

PAGE 3

DEPARTMENTS

Annual Meeting

Delegates to weigh health care solutions

John McNulty

As they did at the 1998 ISMS Annual Meeting, delegates again this year will be pondering managed care issues and AMA deunification.

The ISMS House of Delegates will convene its Annual Meeting next week in Oak Brook, eager to discuss solutions for several hot-button issues including managed care, credentialing and hospital boards.

Medicare: One proposed resolution directs ISMS to call upon the American Medical Association for legal remedies to eliminate the federal government's recent fraud and abuse identification program; the campaign asks senior citizens to inform on physicians suspected of Medicare billing mistakes. In addition, ISMS is urged to seek the AMA's assistance in squelching a proposed

(See Delegates, page 11)

Deunification's back . . .

ISMS' unified status with the American Medical Association will be put on the line once more.

A resolution on the 1999 Annual Meeting agenda asks ISMS delegates to terminate unified status immediately to give members the right to decide on their own if they want to belong to the AMA.

(See Deunification, page 11)

Credentialing passes House, awaits Senate

Legislative UPDATE

BY PAULA KRAPF

A bill that would develop a standardized credentials verification system for physicians recently passed the House with more than 100 votes and has moved to the Senate for a vote. Prospects for adoption in that chamber also look favorable.

The Health Care Professional Credentialing Act would require the Illinois Department of Public Health to develop a standardized credentials verification program to provide guidelines to organizations that want to credential a physician. H.B. 1780 is sponsored by Rep. Angelo "Skip" Saviano (R-River Grove). Sen. Bradley Burzynski (R-Sycamore) is the Senate sponsor.

Several other ISMS-backed bills successfully emerged from either the House or Senate prior to a two-week spring break taken by the legislature that ended April 14. They include the following:

• **Prompt health claim payments** legislation would require insurers to pay clean claims within 30 days and capitation claims within 45 days after an enrollee selects a physician. STATUS: H.B. 2182, sponsored by Rep. Andrea Moore (R-Libertyville), is in the House Rules Committee. S.B. 436, sponsored by Sen. Robert Madigan (R-Lincoln), passed out of the Senate and moved to the House where it is sponsored by Moore and Reps. Tom Dart (D-Chicago) and Elizabeth Coulson (R-Glenview). An ISMS amendment was adopted to H.B. 2713 so that it also requires prompt payment. This bill is before the Senate Insurance Committee, where it is sponsored by Madigan.

• **Hospital peer review good faith immunity** legislation would make a hospital, its employees and staff members involved in peer review liable for civil damages only in the event of wilful or wanton misconduct. Current law provides absolute immunity. STATUS: H.B. 2303, sponsored by Rep. Jay Hoffman (D-Collinsville), was approved by the full House and moved to the Senate, where it is sponsored by Sen. Carl Hawkinson (R-Galesburg).

• **Unfair insurance practices** legislation would make it an unreasonable restraint of trade for a health insurance company to require a physician to participate in all of its plans in order to participate in one or a limited number. STATUS: H.B. 1265, sponsored by Rep. Kurt Granberg (D-Centralia), was passed by the House and moved to the Senate, where it is sponsored by Sen. Dan Cronin (R-Elmhurst).

• **Medical staff privileges denial notice** legislation would include pre-applicants and those requesting an application among persons entitled to privileges. Hospitals would be required to consult with the medical staff prior to closing membership in the entire or any portion of the medical staff or department. STATUS: S.B. 953, sponsored by Sen. James Rea (D-Christopher), was passed by the Senate 59-0 and moved to the House, where it is sponsored by Rep. Tom Ryder (R-Jerseyville).

• **Health care professional advertising** legislation would require all licensed health care providers to include the appropriate academic degree, such as MD, DO, OD and DC, in all advertising and promotional materials. STATUS: H.B. 1441, sponsored by Saviano, passed the House and moved to the Senate, where it is sponsored by Sen. Dave Sullivan (R-Park Ridge).

• **Definition of surgery** legislation would amend the Medical Practice Act to define surgery because Illinois statute does not currently contain a definition of surgery. STATUS: H.B. 874, sponsored by Saviano, is in the House Rules Committee.

• **Death penalty/medical practice** legislation would ensure that the Department of Corrections could not request, require or allow licensed physicians to participate in an execution. STATUS: H.B. 926, sponsored by Ryder, is in the House Rules Committee; S.B. 1169, sponsored by Sen. Arthur Berman (D-Chicago), is in the Senate Judiciary Committee.

• **Prohibition on restrictive covenants** legislation would ban physicians from participating in, offering or making any agreement that includes a restrictive covenant. STATUS: S.B. 925, sponsored by Hawkinson, is in the Senate Licensed Activities Committee.

• **Corporate practice of medicine** legislation would limit entities that employ physicians to: physicians, physician groups, physician corporations, voluntary health service plans, health maintenance organizations and hospitals and hospitals' affiliates. STATUS: H.B. 2143, sponsored by Saviano, is in the House Rules Committee.

Bills defeated include:

• **Helmet requirement** legislation would mandate that children riding motorcycles wear helmets. STATUS: H.B. 802, sponsored by Reps. Sara Feigenholtz (D-Chicago) and Eileen Lyons (R-LaGrange), was defeated on the House floor. ■

Drawn-out malpractice lawsuit finally draws to a close

BY PAULA KRAPF

It took 13 years for the medical malpractice lawsuit DeLuna vs. Treister to make its way twice through Illinois' circuit, appellate and supreme courts. During that time, the case gained a new plaintiff and new plaintiff's attorney; even the Illinois Supreme Court picked up a few new members.

However, two constant factors were orthopedic surgeon Michael Treister, MD, a defendant in the lawsuit, and his attorney, Chicago-based Ruth VanDemark. And in an opinion filed Feb. 19, the Illinois Supreme Court brought the second case to a close in Dr. Treister's favor.

"Many times during this case I would lie in bed and think, 'When is this going to end?' " said Dr. Treister, recalling the cloud of aggravation under which he lived during the lengthy ordeal. But the ruling has Dr. Treister also seeing the silver lining. "I had a feeling as the suit progressed that the fight eventually would be won on behalf of all the doctors in Illinois."

The case of DeLuna vs. Treister (DeLuna I) began in 1986, when Alicia DeLuna died following complications that developed after spinal surgery at St. Elizabeth's Hospital in Chicago. Her husband, Guadalupe, filed suit in a Cook County circuit court alleging that Dr. Treister's negligence caused DeLuna's death. The lawsuit also charged that St. Elizabeth's was vicariously liable for DeLuna's injuries and death. Dr. Treister is chairman of the hospital's surgery department and a member of the medical staff there.

Dr. Treister stayed the course, but in the end the courts never reached an analysis of the care that was provided, said ISMS General Counsel Saul Morse. "Dr. Treister was the flag carrier for what turned into a test case of a new statute."

The case is significant because it carries precedent-setting decisions, he said.

"In DeLuna I, the Supreme Court upheld the constitutionality of a malpractice reform statute that requires plaintiffs to file an affidavit certifying that the case has merit. In DeLuna II, the high court upheld the principle of res judicata that states once a case has been decided, it cannot be filed again."

In 1985, the Illinois General Assembly enacted laws to cut down on frivolous medical malpractice lawsuits. The relevant statute requires a plaintiff filing a medical malpractice lawsuit to include a report from a health professional attesting that the case has merit, as well as an affidavit from the attorney stating that he or she consulted with a health professional.

Because the plaintiff had failed to file the required documents in DeLuna I, the suit against Dr. Treister was dismissed with prejudice in 1986.

DeLuna's attorney then chose to appeal, challenging the constitutionality of the malpractice statute – leading to a 1992 Supreme Court ruling that the statute was constitutional.

But for that statute, this lawsuit would have been over years ago, Morse said.

The case didn't end there, however. In 1993, the DeLuna family returned to circuit court and refiled a medical malpractice action against Dr. Treister and St. Elizabeth's known as DeLuna II. The lawsuit was virtually identical to the original suit, with the exception of a new plaintiff, which allowed the family to refile the lawsuit, said Morse. The eldest DeLuna child, Oscar, filed the complaint because his father died while DeLuna I was pending in the appellate court.

DeLuna II set the stage for the Supreme Court to hear the case once more. This time the high court ruled on the constitutionality of a state rule that forbids reinstating lawsuits if they have been dismissed with prejudice. Finally, in February, the Illinois Supreme Court closed the case against Dr. Treister. The case against St. Elizabeth's is still pending.

"The Supreme Court's DeLuna II decision noted that the case against Dr. Treister had already been decided, and there was no need to hear it again," Morse said. ■

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EDITORIAL

A very dark pot calling the kettle black

Imagine a world in which doctors outline treatment options with their patients without worry that business interests will attempt to censor the conversation.

Imagine, in this utopia, that a doctor reviews the progress of a hospitalized post-operative patient, and recommends – independent of insurance company obligations and objections – that the patient "stay one more day."

Imagine, too, that a patient with a history of angina has direct access to a cardiologist, or that a person with diabetes can simply and easily consult with a dietician.

Once taken for granted, these patient-welfare actions are often just a memory in today's decision-making maze dictated by preapprovals, preauthorizations, utilization reviews and mandatory referrals.

Patient rights legislation pending in the Illinois General Assembly is crafted to streamline the connections between patients and physicians, and place health care decisions back in the hands of those trained in the field of medicine.

Dripping with irony are complaints from opponents of this legislation that it would create too much government interference.

Talk about the pot calling the kettle black!

The very creators of rules, hurdles and barriers between a patient and medical treatment are fretting about interference.

Certainly it is a shame that decisions about what treatment a patient is entitled to receive have become so complicated that legislation is needed to cut through them. But as long as patients' rights to quality health care continue to get trampled, the government has an obligation to act as intermediary.

Two bills show promise of offering such relief. S.B. 579, initiated by ISMS, has passed the Senate, and awaits action by the House. H.B. 626 has passed the House, and awaits action by the Senate. Among their features, these bills give patients clear and timely information about their health care coverage; they allow patients to choose their doctors and gain access to specialty care when needed; and they establish a strong appeals procedure so that medical decisions can be based on the patient's individual needs.

Physicians must call their legislators immediately to speak out in favor of these bills. For fax or phone numbers of representatives in the House or Senate, call ISMS' Division of Governmental Affairs.

Legislative action is long overdue. One year ago, the legislature failed to approve comprehensive health care reform legislation. Many politicians last fall were elected, or re-elected, on the promise that they would take action to end managed care abuses. Now it's time to deliver on that promise.

PRESIDENT'S LETTER

Danger lurks when business meddles in the affairs of medicine

Richard A. Geline, MD

In considering the question of who determines medical necessity, the answer is simple. It has to be the doctor.

As the managed care debate evolves, one of the most contentious arguments centers on the concept of medical necessity. One large national insurance company offers the following definition: "health care services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards and that are likely to result in demonstrable medical benefit, and that are *the least costly of alternative supplies or levels of service which can be safely and effectively provided to the patient.*" (Emphasis added.)

The tenor is unmistakable. Cost concerns will prevail over all other matters. But what is the definition of medical necessity? And who determines what is needed for any individual patient? From the physicians' side of the debate, the reasonable answers are given by the AMA House of Delegates, which defined medical necessity as: "Health care services or products that a prudent physician would provide a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician or other health care provider."

Not unexpectedly, the insurance industry offers counterarguments specifically through a white paper commissioned by the Health Insurance Association of America. It reads, "When the provider, rather than the health plan or insurer, interprets the scope of coverage under the contract, health plans and fiduciaries cannot guarantee to the insured that health care dollars are being spent fairly and equitably on medical treatments that are safe, proven and effective. Indeed, such legislation could give some providers incentives to overtreat patients to enhance their incomes."

The insurance industry clearly believes that the health plan or insurer, rather than the physician, is in a better position to dictate medical treatment. The remark about overtreatment to enhance income insults the entire medical profession. To resort to such allegations suggests a state of desperation in the midst of a losing battle.

Another thought advanced by plans and insurers is that allowing others to make decisions of medical necessity would lead to abuses such as coverage of health club memberships. This is a red herring in the classic sense. Medical necessity should always be based on a prudent physician standard legally and medically not subject to abuse by any party.

In considering the question of who determines medical necessity, the answer is simple. It has to be the doctor.

■ ■ ■

The past year of service as your president has gone by with remarkable speed. It seems like only yesterday I was preparing to step into office, and now it is time to step down. In that process, a number of observations leap to mind.

Considering the environment in which we practice, with all manner of forces pulling us in so many directions, the need for organized medicine to protect patients' interests, as well as the centuries-old core values of our profession, has never been greater.

The dialogue began long before my term and will continue long afterward. We can take comfort that for the next year the role of ISMS president will be most ably filled by Dr. Clair Callan.

Fortunately, we are blessed with a marvelous Illinois State Medical Society staff working to solidify the principles that guide us as physicians. It is hard to give enough thanks and credit to these talented and dedicated people.

Finally, the opportunity to meet ISMS members from all corners of Illinois has amplified my appreciation for physicians as an extraordinarily intelligent, well-meaning and industrious group of individuals. It has been a pleasure to serve you this past year. Thanks for the privilege.

ISMS on record

Recent articles in Illinois newspapers show that ISMS is carrying the voice of physicians across the state. Through editorials, letters and interviews, ISMS President Richard Geline, MD, is showcasing the Society's stand. Here are some clips:

Medical society chief touts reform

Bloomington Pantagraph Feb. 10, 1999

"Illinois doctors are close to winning the political game for managed care reform, according to their team captain for this year. 'We're on the 10-yard line, and we want to push it to the end zone,' said Dr. Richard Geline, president of the Illinois State Medical Society for 1999. Geline was referring to Illinois House Bill 579 – the medical society's Managed Care Patient Rights Act." ■

Medicare "bounty"

Chicago Daily Southtown March 5, 1999

Letter to the editor from Dr. Geline

"What kind of confidence could a patient possibly have in the clinical judgment of a professional that the government has asked that patient to check out for fraud? Yet confidence is the cornerstone of the doctor-patient relationship, which itself undergirds the quality of patient care. The effect that loss of confidence could have on the care patients receive is chilling. Doctors, through our professional organizations such as the Illinois State Medical Society and the American Medical Association, have zero tolerance for fraud . . . ." ■

Panel OKs bill allowing suits against HMOs

Chicago Daily Law Bulletin Feb. 11, 1999

"Legislation that would allow patients to sue their health maintenance organizations for malpractice has advanced, with a House committee approving the bill along straight party lines. . . . 'As the managed care experiment continues, the authority to make decisions is being taken out of the hands of physicians and put into the hands of managed care providers. Accountability would follow authority,' said Dr. Richard A. Geline, president of the Illinois State Medical Society, an organization of 18,000 physicians." ■

Managed care reform essential, says medical society leader

Iroquois County Times-Republic Jan. 21, 1999

"The right of doctors to be patients' advocates and to protect patient rights needs to be resurrected. Dr. Richard Geline, president of the Illinois State Medical Society, emphasized that in Watseka during his address to the physicians of the Iroquois County Medical Society . . . .'We have a managed care patient rights act proposal before the Illinois General Assembly at this time,' he said. 'Its thrust is to bring back the doctor-patient relationship.'" ■

Don't yield health care power to the few

Rock Island Argus Feb. 1, 1999

Letter to the editor from Dr. Geline

"Aetna, through its recently announced $1 billion purchase of Prudential Insurance Company's health care business, is poised to grab a stranglehold over patients and doctors that threatens the quality of health care. Doctors think it is unhealthy for that much power to be concentrated in a single set of corporate hands. . . .Without reasonable, enforceable patient rights laws in place, it's just not healthy to give billion-dollar corporate behemoths like Aetna power that is denied the doctors, and their patients, on Main Street." ■

Ron Ackerman

ISMS President Richard Geline, MD, (right) meets with Springfield Journal Register reporter Tony Cappasso at the Capitol.

Euthanasia has no place in practice of medicine

Bloomington Pantagraph Dec. 2, 1998

Letter to the editor from Dr. Geline

"As offensive as it was, the decision by CBS' '60 Minutes' to broadcast . . . the killing of a suffering person by Jack Kevorkian could possibly produce some good in spite of itself. . . . It would be good if the repulsive scene . . . moves patients and families to seek out the many caring and compassionate options that are available for end-of-life care, and spurs doctors to redouble the efforts we're making to teach and implement the better ways we have to care for our disabled, depressed, aging and terminally ill patients." ■

Help win the fight

Chicago Sun-Times Feb. 9, 1999

Letter to the editor from Dr. Geline

"Walter Payton gave us memories we'll share with our grandchildren. We can do something to help him – and everyone else who needs a transplant – fight their toughest opponent. Pull out your driver's license and make sure there's a Y in the spot marked 'donor.' If not, call (800) 210-2106 and sign up as an organ donor with the Illinois Organ/Tissue Donor Registry. " ■

Medical president calls for reform in managed care

Danville Commercial News Feb. 3, 1999

"Dr. Richard Geline says now is the time for managed health care reform. Tuesday night, Geline, president of the Illinois State Medical Society, told members of the Vermilion County Medical Society that grassroots contact from patients can motivate lawmakers to carry through on reforms." ■

LETTERS

"Patient Rights All-Stars" a hit

I enjoyed the "Patient Rights All-Stars" section in [March 5] Illinois Medicine. I think this format, with names and pictures, could [also] be used to identify politicians who back legislation that is hostile to physicians and medicine. These legislators can be better identified so physicians in their districts can talk to patients about them.

Jeffrey Altman, MD
Arlington Heights, Ill.

Coming soon: Keeping abreast of drug warnings

ISMIE Update

Upcoming ISMIE seminar

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June 4, Oak Brook

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Staying in touch takes

Engagement Empathy Education

Tips for sharpening physician-patient communication

BY PAULA KRAPF

A simple misstep in the *pas de deux* of physician-patient communication could place this relationship on rocky footing. Instead of achieving diagnostic accuracy and patient adherence, physicians could face malpractice risk and litigation.

To avoid physician-patient communication breakdowns, doctors need to realize that they often must apply the skills of a social worker and a psychologist, said Herb Sohn, MD, a urologist and attending physician at the University of Chicago/Louis A. Weiss Memorial Hospital. "Physicians need to know the fundamentals of talking to patients just as they know the clinical side of their practice," said Dr. Sohn, who frequently leads ISMIE physician-patient communication seminars.

In his presentations, Dr. Sohn emphasizes the three "E's": engagement, empathy and education. Engagement entails connecting with patients to establish trust in the relationship, said Dr. Sohn. For example, doctors could question new patients about what they do for a living or how they spend their time.

With returning patients, physicians can mention a personal anecdote from a previous visit. From that point, physicians can encourage patients to explain the outcome they desire from the visit.

Empathy involves seeing, hearing and accepting patients' experiences. "Too often, doctors ask their patients what's bothering them and then interrupt them 18 seconds later," said Dr. Sohn. Interrupting patients can make them feel that the doctor doesn't care about them.

Because patients want to talk about their illness, physicians should ask open-ended questions and repeat what the patient has said, continued Dr. Sohn. Not only does that reassure patients that their doctors have heard them, it also provides physicians with more detail about their patients' problems. Furthermore, if doctors miss a key point, their patients can let them know.

Education is an important step to ensure that patients understand their diagnosis and prognosis.

Typical concerns on most patients' minds include: what action their doctor will take (such as a medical test); why their doctor will take that action as opposed to another option; the duration and effects of the diagnosis and treatment; and when they will learn test results.

Timely release of information is essential, Dr. Sohn said. "Doctors should give patients a date for test results, stay in touch and follow up."

After discussing actions, options, diagnosis and treatment, physicians should make certain the patient understands all the information and should encourage the patient to ask questions, Dr. Sohn added.

Good communication is important not only between physicians and patients but also between physicians and staff members, said David Drake, an attorney and senior partner at the Springfield law firm of Drake, Narup & Mead. A patient might ask the nurse or medical assistant a question related to his or her treatment and receive assurances that all is fine, but that conversation is not relayed to the physician. If complications arise later, that unreported message could wind up the crux of a lawsuit.

"I tell physicians that their employees need to know that anything their patients say must be clearly communicated to the doctor and documented. If employees have any questions about patients' comments, they need to let the physician know," Drake said.

Although good communication is crucial to good care, there are some topics that must be off limits between patients and physicians, Drake said.

"There are cases in which comments to a patient by a subsequent treating physician that may appear critical of the initial treating physician could unfairly lead to a malpractice lawsuit," he said.

Drake estimates that nearly 50 percent of litigants cite a comment made by a subsequent treating physician as the impetus for filing a lawsuit.

For example, asking a patient, "Why wasn't this fracture fixed sooner?" could be misconstrued. The subsequent treating physician should limit comments to information necessary for the diagnosis and treatment and not offer opinions that are not relevant to patient care.

Although the physician-patient relationship has changed under managed care's pressures, Drake believes that doctors and patients still make good partners.

"A lot of trust remains between patients and their physicians, and physicians can build on that partnership by spending more time with their patients," said Drake. ■

Illustration by Tim Grajek/SIS

MALPRACTICE ROUNDUP

Physician's personal drug use an issue in Georgia lawsuit

Whether a physician has a duty to disclose his or her use of illegal drugs was the issue in a malpractice case decided by the Georgia Court of Appeals last year.

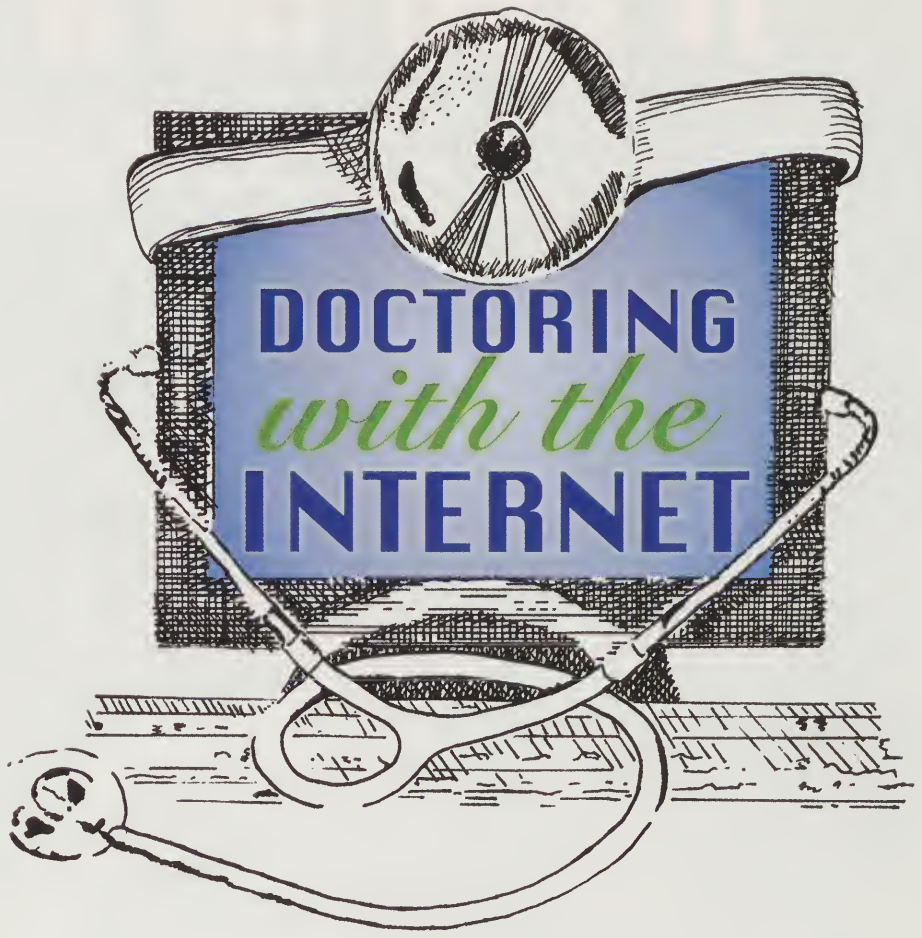
In Cleveland vs. Albany Urology Clinic, reported in the December 1998 issue of Medical Malpractice Law & Strategy, the appellate court ruled that a physician has a duty to disclose his use of illegal drugs to a patient before performing surgery, regardless of whether he is under the influence of the drug at the time of surgery.

The plaintiff sued the clinic and one of its physicians on several counts, including fraudulent concealment of the physician's use of cocaine. The plaintiff claimed that the physician had negligently diagnosed his condition as cancer of the penis and performed unnecessary surgery, whereas the plaintiff was actually suffering from a benign disease usually treated with vitamin E.

Although the jury decided in favor of the plaintiff, the trial court granted the defendants' motion for judgment notwithstanding the verdict, finding that the physician had no duty to disclose his use of cocaine.

The appellate court, however, overruled the trial court, finding that the plaintiff's claim for negligent concealment was supported by law. The court held that the physician's cocaine use was a material fact that should have been disclosed to the plaintiff prior to surgery.

In its commentary, Medical Malpractice Law & Strategy pointed out a troubling aspect of the Cleveland verdict, observing, "Clearly, a physician's medical judgment can be impaired by the use and abuse of illegal drugs, and patients need to be protected from errors in medical judgment resulting from such addictions. However, the Cleveland decision raises an issue as to whether a physician must disclose that he or she occasionally uses alcohol or is taking prescription medications that may affect his or her judgment."



Turn online for help to heal the sick, save the dying, and ease pain and suffering.

BY JANICE ROSENBERG

Remember when the web was something woven by spiders and online was a place for drying laundry?

Ahhhh, enter the Internet, a computer-age wonder that quietly slipped through the back door of the 20th Century and quickly became a leading contender to win the title of the technological advancement to have the greatest impact on the coming millennium.

Although its uses range widely – e-sales, homework helper, love connector – nowhere is its potential as great as in the medical world, where it is used as a tool to help heal the sick, save the dying, and ease pain and suffering.

Physicians increasingly are taking advantage of its services, discovering, for example, that rare diseases are not nearly so rare when the patient pool spans the globe. David Loiterman, MD, a vascular surgeon from La Grange, seeks advice online from colleagues around the world when a patient comes to him with an infrequently seen problem. "I post the problem, and within 24 hours, get feedback from physicians who've seen a similar problem," he said.

Rather than waiting for each Yearbook of Vascular Surgery, Dr. Loiterman uses the Internet daily to keep abreast of his field through sites such as Healthfinder, the Centers for Disease Control and Prevention and the National Guideline Clearinghouse (see Sites To Try, this page).

He also regularly consults a huge database known as Micromedex. "It is constantly updated on treatment protocols and drug information," said Dr. Loiterman. "I had a patient who was taking three different drugs and wanted to take an over-the-counter antihistamine that has several other medications in it. In 10 or 15 minutes I was able to download information on all the medications, look at their interactions and recommend what he should do."

Although some physicians rely heavily on the Web for information, colleague connections and access to the latest research, other doctors have barely gotten their feet wet, said William Werner, MD, MPH, ad hoc Web committee chairman for the Chicago Medical Society, who conducts seminars entitled "Medicine on the Internet."

Dr. Werner's lecture-demonstration shows attendees how to access a variety of health-related sites on the World Wide Web; evaluate Web site information for source, content and currency; and conduct searches on health care-related topics using several search engines. With a little help, even physicians who have never touched a keyboard can quickly move beyond demonstration screens to sites showing mortgage rates or the latest basketball scores – exercises designed to show how enjoyable Internet research can be.

"I use the computer at home as a typewriter," said Raymond McDonald, MD, a Melrose Park internist who attended a recent seminar by Dr. Werner at the CMS Midwest Clinical Conference. "But this has given me a hint of the power of the Internet – and it was fun."

A great Internet application, according to Dr. Werner, is to track information on "underground" medicine. "One of my patients – a body builder – was taking creatine and I had no idea what that was," said Dr. Werner, who is assistant professor of medicine at Rush Medical College, and vice president for quality management at Illinois Masonic Medical Center. "I looked it up on the National Institutes of Health site for alternative medicine and got some good, basic information," he said.

Another incentive for physicians to become Internet savvy is that their patients increasingly are, said Dr. Werner. Anyone can establish a Web site, and patients are running into inaccurate information, he pointed out. Physicians who check out health care sites frequented by the public can stay one step ahead of their patients who arrive for an appointment with information gleaned from the World Wide Web.

To combat outrageous and inaccurate claims, Dr. Werner recommends that physicians learn how to send patients to Web sites run by recognized authorities. The Doctor's Guide to Breast Cancer, the American Heart Association and the American Academy of Pediatrics are a few of many reliable Internet choices (see Sites To Try, this page).

"I was developing a guideline on hypertension for my patients and found very useful information on the American Heart Association site," said Dr. Werner. "I used to tell patients to buy the AHA book, but now I print the guideline right off the Web and hand it to them." ■

Illustration by Julia Anderson-Miller

Sites To Try

Medical Organizations

American Academy of Pediatrics – http://www.aap.org
- Click on "You and Your Family" to see the 1999 immunization schedule.

American Medical Association – http://www.ama-assn.org
- Use the "Doctor Finder" feature to retrieve info on any physician nationwide.

Chicago Medical Society – http://www.cmsdocs.org
- Links to a wide variety of medically relevant sites.

Illinois State Medical Society – http://www.isms.org
- Click on "Physician Advocacy" to reach updates on legislation affecting physicians.

Government Agencies

Centers for Disease Control and Prevention – http://www.cdc.gov
- Click on "Travelers' Health" to access up-to-date health recommendations for patients going abroad.

Healthfinder – http://www.healthfinder.gov
- Links to hundreds of health publications and Internet health sites.

National Center for Complementary & Alternative Medicine – http://altmed.od.nih.gov
- Contains more than 180,000 biblographic citations organized by disease.

National Guideline Clearinghouse – http://www.guideline.gov
- Resource for evidence-based clinical practice guidelines.

National Institutes of Health – http://www.nih.gov
- Information and research on disease detection and prevention.

National Library of Medicine PubMed – http://www.ncbi.nlm.nih.gov/PubMed
- Retrieve medical article abstracts; order complete articles.

Specific Diseases

Asthma

Mayo Clinic – http://www.mayo.edu/int-med/asthma/provider.htm

Breast cancer

Doctor's Guide to Breast Cancer Information & Resources – http://www.pslgroup.com/breastcancer.htm

Diabetes

American Diabetes Association – http://www.diabetes.org

Heart disease

American Heart Association – http://www.americanheart.org

Miscellaneous

Medical Matrix – http://www.medmatrix.org
- Find groups for nearly every medical specialty.

Micromedex – http://www.mdx.com
- Comprehensive clinical decision support databases.

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Need audit assistance?

ISMS will advocate for members who want information, assistance or a legal referral for Medicare or Illinois Department of Public Aid audit difficulties.

In addition, members who want to serve as a peer reviewer for IDPA's medical quality review process should contact the Society.

These matters can be directed to ISMS' Health Care Finance Division by calling (312) 782-1654.

Medicaid

(Continued from page 1)

patients to look for evidence of fraud in their bills.

The initial Medicare study, which was performed by the federal Office of the Inspector General in 1996, found that the program had an error rate of nearly 14 percent. Subsequent reviews, however, have shown that the Medicare error rate has declined by nearly half, to 7.1 percent. That figure is not too far off from Illinois' MAP findings, Bradley noted.

ISMS physicians commended the IDPA's survey results. "It's encouraging to see such a good report on how physicians are doing for our citizens," said TPPP Committee Chairman Richard Snodgrass, MD.

IDPA undertook the MAP review in January 1998 to establish a baseline against which future payment accuracy can be measured.

The in-depth IDPA review examined the records of 599 clients on whose behalf payments were made. Claims from physicians, pharmacies, hospitals and hospices were subject to in-depth scrutiny. Services provided through other state agencies, long-term care, managed care and capitation payments and Medicare/Medicaid crossovers were bypassed because those systems are too complex to be included, Bradley said.

First, IDPA staff determined whether medical records substantiated the billing sent to the agency and whether the patient received the service listed. Those reviews were followed up with audits of physician and other providers' offices, visits to clients who received services and medical record reviews performed by nurses.

After categorizing each service as correctly paid or in error, the department divided the errors into three categories: agency error, in which IDPA approved payment in unintentional violation of its policy; inadvertent errors, or billing mistakes; and questionable errors, in which the provider's intent to bill correctly was in doubt although no intent was proven.

The findings include the following:

- The most significant problem occurred with non-emergency transportation claims, which accounted for 54.7 percent of overpayments. Interviews with patients determined that in many of those cases, the documented trip never occurred. IDPA will follow up on those cases, Bradley said.
- IDPA error composed 23.4 percent of overpayments.
- Physician or provider error was the smallest category, accounting for only 22 percent of overpayments. In most cases, doctors had chosen one CPT code, but IDPA selected another based on physicians' billing records.

"These aren't intentional mistakes," said Bradley, who acknowledged that the CPT codes are complex. However, many physicians could do a better job of documenting their services. If their billing records don't make it clear what service was provided, the IDPA won't pay for that service, he added.

Despite IDPA's good news, 5 percent of the MAP's claims are erroneous. Those inaccurate claims amount to approximately $113.5 million of the $2.4 billion portion of the MAP budget that IDPA scrutinized. Still, the IDPA's error rate is significantly lower than the 10 percent error rate Medicare cited following its 1996 study, Bradley added.

Several state-of-the-art MAP integrity initiatives are under way or planned following the IDPA's payment accuracy report, including the following:

- Automating the prior approval requests for non-emergency transportation so the transportation will be used only for authorized medical services.
- Contracting with a single entity that would administer and deliver non-emergency transportation services.
- Developing better checks and balances for payment programs.
- Unifying the several existing claims databases into a single system for greater efficiency and accuracy.

"We have to find better ways to use the data available to us so we can address our deficiencies and leave the honest providers alone," said Bradley. ■

IMPAC Annual Meeting scheduled for April 23

The Annual Meeting of the Illinois State Medical Society Political Action Committee will take place April 23 at the Oak Brook Hills Resort and Conference Center. The meeting is open to all IMPAC members and will begin immediately after the ISMS House of Delegates morning session.

Business will include the election of IMPAC Council members. Nominees for appointment or reappointment to the council are Albino Bismonte Jr., MD, Gurnee; James Bull, MD, Silvis; Alfred Clementi, MD, Arlington Heights; Norman Johnson, MD, Pekin; Janis Orlowski, MD, River Forest; Aldo Pedroso, MD, Chicago; Kenneth Printen, MD, Evanston; Albert Ray, MD, Joliet; Ronald Simone, MD, Geneva; Arthur Traugott, MD, Urbana; Neil Winston, MD, Chicago.

Deunification

(Continued from page 1)

Although deunification has been weighed by the House many times in the past two decades, the Society has continually voted to preserve unified status. The most recent deunification vote occurred at a House of Delegates special meeting last September, held specifically to consider eliminating Illinois' unified status. The vote was essentially evenly divided, falling far short of the required two-thirds needed to make such a change to the Society's bylaws.

Several other resolutions related to ISMS' relationship with the AMA will be considered at the Annual Meeting. Salaries and perquisites of AMA officers and board members is the topic of a resolution asking the AMA to provide detailed information on the compensation and benefits given to all of its elected officers and board members.

The AMA's January firing of George Lundberg, MD, as editor of the Journal of the American Medical Association inspired a resolution demanding that ISMS' Board of Trustees explain why it supported the AMA's action. The resolution also asks that ISMS request the AMA's House of Delegates to form an ad hoc committee to investigate possible policy violations by the AMA's senior staff and Board of Trustees. In addition, ISMS will be asked to present its members with a report detailing any financial losses sustained by the Society as a result of its unified status.

Another resolution wants ISMS to oppose one aspect of a proposed AMA product endorsement policy that appears to allow the Association to endorse products if it designs, produces or controls them. In the wake of the soured Sunbeam-endorsement deal, some ISMS members do not want the AMA to endorse commercial products for any reason. The AMA's House of Delegates will debate that policy recommendation at its annual meeting in June. ■

Delegates

(Continued from page 1)

fraud data bank that would contain the names of physicians convicted of Medicare fraud.

A second resolution seeks to arm physicians with more knowledge of federal fraud and abuse legislation, as well as enforcement programs. ISMS is asked to develop education programs, offer legal assistance, conduct mock audits and compile records of fraud and abuse incidents involving physicians.

Credentialing: This resolution seeks a unified credentialing form through the American Medical Accreditation Program, which will help eliminate duplication and redundancy in credentialing. Additional resolutions address the need for a uniform credentials verification entity through AMAP and a universal, timely means for credentialing new physicians.

This year's ISMS Annual Meeting will be held April 23-25 in Oak Brook. For a full report, check the May 7 issue of Illinois Medicine.

Solo practices: A resolution urging the Society to assist solo physicians was introduced in response to the decline in their ranks in the wake of managed care's push for employment contracts and group practices. Items requested in the resolution include a network for solo physicians to collaborate with their peers.

Hospital board members: Relations between hospitals and medical staff, strained by managed care, fueled a resolution seeking to define the medical board as an independent organization. As such, the board would have a binding contract with the hospital that could not be changed without the consent of both parties.

Unions: Physicians' lack of clout in dealing with insurance companies, the government, managed care organizations and hospitals is addressed in a resolution that asks the Society to investigate whether ISMS can form a collective bargaining unit.

The 1999 House of Delegates will meet April 23-25 at the Oak Brook Hills Resort and Conference Center. Far fewer resolutions have been introduced this year – 63 compared with last year's record-setting 106. Late resolutions accepted after the deadline, which require special approval, may add to that total. ■

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(Classifieds continued from page 12)

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Workshop to focus on improving end-of-life care

"Last Acts: Leverage Points," a regional workshop on improving end-of-life care, will be held April 28-29 at the Chicago Marriott Downtown Hotel. Geared toward medical and nursing professionals, administrators and state medical specialty society leaders, the workshop is part of a concerted national effort to develop policies that promote good care of the dying.

The workshop opens Wednesday evening with registration, a welcoming reception and a performance by Voces Novae, a community chamber choir from Bloomington, Ind., that will demonstrate the role of music in the end-of-life movement.

On Thursday morning, a keynote address and panel discussion will center on how the states have handled end-of-life issues, the advantages and disadvantages of legislating in this area and alternative approaches. Morning workshops will follow, with participants able to choose among the five sessions offered: delivering excellent pain and symptom management, seeking a seamless transfer across health care settings, financing high-quality end-of-life care, training health care professionals and developing a strategy for educating the public. Those sessions will be repeated in the afternoon.

The workshop, sponsored by Last Acts, a national coalition to improve care and caring at the end of life, will conclude with a panel discussion of ways the media shape public perceptions.

There is no fee. Registration may be faxed to Victoria Boczkowski at (312) 642-1888. For more information, call (312) 642-4236. ■

"Your Health Matters" is on the move

The process of distributing Your Health Matters, the ISMS monthly health commentary column geared toward patients, has changed. Beginning this month, ISMS members and the media can register to regularly receive the column via e-mail or fax. Contact the ISMS Public Relations Department at (800) 782-ISMS or pr@isms.org. to be added to the distribution list.

The column will continue to be available from the Patient Health Resources section of the ISMS Web page: http://www.isms.org/patient/yourhealth.html.

In the past, order forms were provided twice annually to ISMS members interested in obtaining specific Your Health Matters titles for their patients.

Settlement

(Continued from page 1)

579 would not.

"I'm optimistic that S.B. 579 will be the bill to pass out of the House and reach Gov. Ryan's desk," said Sen. Thomas Walsh (R-Westchester), the bill's Senate sponsor. Although some Democrats prefer that a patient rights bill contain a liability provision, Walsh said he and other Republicans do not support legislation that gives patients the right to sue their HMOs.

"Consumers who seek patient rights laws ask for more access to specialists and for emergency room care without preauthorization, but not for the right to sue their HMO," Walsh said.

The liability issue must and will be decided by the courts, added Walsh, who noted that the Illinois Supreme Court's current docket includes Petrovich vs. Share. In that case, the plaintiff, Inga Petrovich, has held Share Health Plan of Illinois vicariously liable for the treatment decisions made during her bout with cancer.

Rep. Jeffrey Schoenberg (D-Wilmette) will shepherd S.B. 579 through the House. The bill is similar to H.B. 579, which he cosponsored, although that bill never moved beyond the House Health Care Availability and Access Committee. The committee backed H.B. 626 instead – the bill sponsored by its chairman, Rep. Mary Flowers (D-Chicago).

Still, Schoenberg believes S.B. 579 has the most realistic chance of being approved by the Legislature. By passing S.B. 579, the Senate has outlined the health plan reform policy changes that its members found acceptable. "Now the responsibility is for the House to either embrace or slightly modify the bill in a way that can ensure acceptance of those changes if the bill should return to the Senate," he said.

The components of S.B. 579 are more palatable for a majority of legislators, he noted. For instance, S.B. 579 would allow consumers to appeal treatment decisions to an independent review panel. It also addresses the root causes of the growing number of uninsured citizens by expanding the ability for multiple employers to enter into insurance purchasing groups.

Moreover, S.B. 579 is the result of a diverse coalition that has worked hard for two years to reach agreement on meaningful reform, said Walsh. ISMS and the business community, in particular, ironed out their differences. Lawmakers, physicians, consumers and others can continue to monitor the managed care industry once a bill becomes law to weigh its impact on the affected parties. Further changes can be made then, if necessary, he added.

Preliminary negotiations on S.B. 579 are already under way and should hit full steam when the General Assembly reconvenes April 14. The availability of time, compared with the tight time constraints of past years, should give legislators more time to forge a compromise, Schoenberg said.

"We are hopeful that meaningful reform will pass the Legislature this session," said ISMS President Richard Geline, MD. Dr. Geline noted that ISMS continues to win the support of a range of organizations such as the Illinois Chiropractic Society, the American Association of Retired Persons, the Illinois Nurses Association and the Governor's Commission on the Status of Women in Illinois.

Lawmakers may have more incentive this year to pass a reform bill, Schoenberg said. The citizens of Illinois are watching closely, and have little patience with the empty promises of prior years. In addition, the bipartisan spirit of cooperation ushered in with Gov. George Ryan's administration will influence the outcome of patient rights legislation.

"By establishing managed care patient rights reform as a top priority in his administration, Gov. Ryan has issued the challenge to the General Assembly to put results ahead of the political rhetoric," Schoenberg said. "I do anticipate that Gov. Ryan will weigh in personally if need be in order to ensure that no one walks away from the bargaining table empty-handed this year." ■

BCBS

(Continued from page 1)

considering similar endeavors. Physicians and insurers must collaboratively address reimbursement and other payer issues, he added.

The incentives plan that the Blues unveiled last October would have paid podiatrists, orthopods and other physicians who performed 55 Blues-approved foot and ankle surgeries in their office an added $200. As worded, the initiative would have subtracted $200 from payment to physicians who performed those procedures in a hospital or surgicenter.

The plan hit strong objections from ISMS and specialty physicians including the Illinois Podiatric Medical Association. The Blues, meanwhile, explained that their claims database revealed that more than 50 percent of the targeted foot and ankle procedures already were being performed in an office. Yet many physicians felt the incentives plan was potentially penalizing physicians for performing those surgeries in an appropriate setting.

Although TPPP members are aware that some insurers are beginning to place pressure on physicians to perform more outpatient surgeries in their offices, they feel that physicians should be the ones who determine whether a site is appropriate for a given procedure.

"If we give in [to insurers' demands], some bad things are going to happen, and certainly, there will be some real discomfort for the patient," said TPPP member Robert Hamilton, MD.

In addition, there are potential regulatory and quality of care issues to consider if physicians perform more office-based surgeries, TPPP members added, echoing the concerns raised by ISMS and IPMA. ■

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Q&A: TRANSITION DETAILS FROM NEW MEDICARE CARRIER (PAGE 5)

Illinois Medicine

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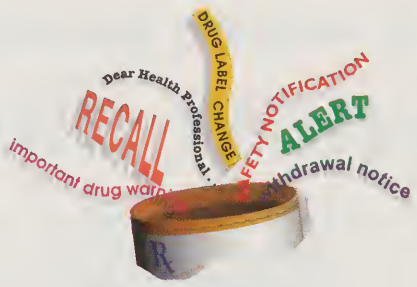
your new president!

PAGES 3 & 4



Staying abreast of drug warnings

PAGE 6

ANNUAL MEETING REPORT

Collective bargaining a go; AMA tie stays for now

Delegates seek strength in numbers

BY PAULA KRAPF

[OAK BROOK] Spurred by the pleas of a vocal majority urging that physicians "take back their profession," ISMS' House of Delegates voted overwhelmingly in favor of requiring the Society to establish a collective bargaining unit.

The passionate voices that endorsed the resolution drowned out the few delegates who opposed the measure during the April 25 session of the House of Delegates Annual Meeting.

"Collective bargaining is what your younger physicians want," medical student Sharyl Truty told the House of Delegates.

"It's time for us to stand up for ourselves," said Michael Vidas, MD, a delegate from the Peoria Medical Society.

On the surface, the resolution chiefly addressed physicians' grievances with managed care.

"Physicians need a voice," said M. LeRoy Sprang, MD, the Society's president-elect.

Forming a collective bargaining unit would set a place at the table for current and past ISMS members to meet with health care providers to discuss how to provide quality patient care, added Kenneth Printen, MD, a member of the Board of Trustees.

"Approximately half of current doctors are salaried, and many young physicians will be salaried. They need someone to represent them," said Joseph Murphy, MD, 2nd vice president of the ISMS Board of Trustees and the resolution sponsor. Legislative initiatives have not accomplished the desired results on either the state or national level, he said. A recent Chicago Medical Society survey revealed that approximately 50 percent of its members

(See Strength in numbers, page 13)

A sea of hands at the ISMS Annual Meeting in Oak Brook votes affirmative to the Society's forming a collective bargaining unit for physicians.

Unification vote: a narrow "victory"?

Despite membership survey results, unified status remains

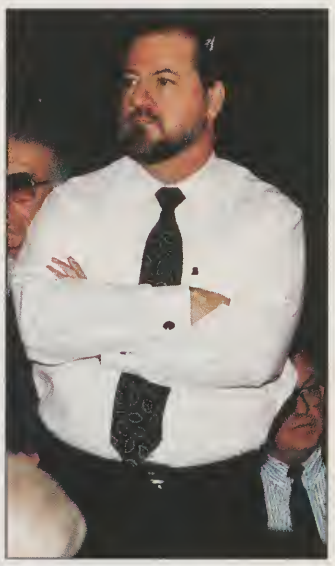
BY PAULA KRAPF

[OAK BROOK] Despite overwhelming support in favor of breaking membership linkage with the AMA, the ISMS House of Delegates fell just three votes short of the two-thirds majority required to deunify.

Only three other states have maintained unified membership status with the AMA.

Delegates at the Annual Meeting where the vote was taken gasped when they heard the 125-66 secret ballot result. "The close call is the worst of all possible outcomes," said Rodney Osborn, MD, who coauthored the deunification resolution. Dr. Osborn asked for a reconsideration vote to develop the

(See ISMS stays unified, page 14)



Photos by John McNulty

Deunification proponent Rodney Osborn, MD, said his delegation will begin working again for a consensus to delink.

State launches PR campaign to put the kids in KidCare

BY PAULA KRAPF

Illinois' largely underutilized KidCare insurance program is receiving a shot in the arm through a publicity drive. The state-wide effort will target physicians, other health care providers, schools, clergy, and community and business leaders.

The campaign, which includes paying physicians a $50 technical assistance fee for every application that results in a new enrollee, aims to add at least 2,000 children per month to the 16-month-old program.

Launched in January 1998, KidCare is a state-run insurance program that offers health coverage for children through age 18 as well as pregnant women who meet the income requirements. In addition, KidCare helps eligible families pay premiums for employer-sponsored or private insurance plans.

Given the need for KidCare, the existing membership level is unacceptable, said Ann Patla, director of the Illinois Department of Public Aid, which administers the program.

KidCare's phase one automatically enrolled nearly 29,000 children and pregnant women who had been Medicaid recipients. Stage two, which began in the fall of 1998, brought in only 3,000 additional enrollees. Yet state officials have estimated that between 100,000 and 200,000 low-income children and pregnant women in Illinois are eligible for KidCare coverage.

Patla noted that reaching eligible working families has been

(See KidCare, page 13)

Markus Giolas

Ann Patla, director of the Illinois Department of Public Aid, talks to a member of the media during a recent news conference announcing a campaign to increase KidCare enrollment.

INSIDE

ISMS strategic plan adopted

A new direction

ISMS will begin streamlining its programs and services following the House of Delegates' adoption of the strategic plan at the Annual Meeting, held April 23-25.

ISMS formed an Ad Hoc Advisory Committee on Strategic Planning last fall to reevaluate the Society, from its mission statement to its councils, and recommend changes that would make ISMS more efficient organizationally and financially.

The Board of Trustees will use its business planning process to implement the strategic plan, which includes the following changes:

• An updated mission statement that reads: "The Illinois State Medical Society is a professional organization that represents and unifies its physician members as they practice the science and art of medicine. The Society represents the interests of member physicians, advocates for patients and promotes the doctor-patient relationship, the ethical practice of medicine and the betterment of the public health."

• Funding will be discontinued for the Organized Medical Staff Section, the Committee on CME Accreditation and the CME Accreditation Appeals panel, which will all attempt to become self-funded. If this fails, ISMS will abolish these functions at the House of Delegates Annual Meeting in April 2000.

• Overlapping committees will be incorporated into a single entity and new committees created to meet members' needs. The Third Party Payment Processes Committee will become part of the Council on Economics; the Council on Mental Health and Addiction and the Council on Health Care Access will be incorporated into the Council on Medical Service. To increase advocacy, ISMS will create a Council on Membership and Advocacy that will assume new duties in addition to some of the former duties of the Council on Public Relations and Membership Services. After a study of communication needs is completed, the Council on Communication will take over the remaining functions of the Council on Public Relations and Membership Services.

• The Board of Trustees will study the potential for savings in rent and other expenses that could be achieved by moving ISMS' Chicago headquarters to Springfield.

In other Annual Meeting actions, delegates voted to:

• Support a resolution stating that drugs should be prescribed for patients based on what is best for patients, regardless of cost.

• Have the Board of Trustees study whether to develop a definition of "primary care physician," because existing ISMS policy does not now include a definition.

• Encourage state legislation that requires managed care organizations to grant temporary credentials to physicians who have completed a residency approved by the Accreditation Council for Graduate Medical Education and who are hired to provide patient care services.

• Encourage the pharmaceutical industry to stop the mass advertising of prescription drugs and pass those savings to patients.

• Support or cause to be introduced new legislation in the Illinois General Assembly mandating caps on malpractice awards.

• Refer to the Board of Trustees for further study the issue of whether health care in this country is a right or a privilege.

• Ask ISMS' Board of Trustees to decide whether the Society should file a class action lawsuit against Blue Cross Blue Shield of Illinois for the destruction of legitimate Medicare claims in one of its offices.

• Have the Board of Trustees decide whether to negotiate with all insurers to see if they will offer the Society's members a reduced price for professional liability premiums. ■

Is your office in compliance?

To help you protect yourself against unwarranted fraud and abuse investigation, ISMS has developed a seminar on recent changes in Medicare law. The Society has gathered a panel of experts on third-party payer and related coding issues, fraud and abuse investigations and self-referral laws; the speakers include two partners from the Chicago law firm of Sidley and Austin, as well as a consultant in medical office management.

The day-long program will feature a morning session on fraud and abuse, the Federal False Claims Act and development of compliance plans; the afternoon session will focus on effective CPT coding. ISMS members and their staffs may register at the special membership rates of $95 (full day) per person or $65 (half day).

The program will be held in four locations on the following dates: June 15, Collinsville; June 16, Springfield; July 14, Rockford; and July 15, Oak Brook. Please watch the mail for specific registration materials. For more information, contact the Division of Health Care Finance at (800) 782-4767. ■

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"Failure is not an option"

BY PAULA KRAPF

New ISMS president ready for legislative, membership challenges

At a time when strength in numbers has become a physician survival mantra, yet organized medicine has lost its luster for some doctors, Clair Callan, MD, is well suited to be ISMS' paladin.

"One of my traits is to never give up," said the Society's new president, an anesthesiologist currently serving as a vice president for Abbott Laboratories near North Chicago. "I will do whatever I can, no matter how often I'm rebuffed, to retain and attract members," Dr. Callan explained, emphasizing that this is at the top of her agenda for the year ahead.

Younger physicians especially must be brought into the fold, she said. Unlike the older ISMS members who entered medicine when solo practitioners were the norm, "we're now getting physicians who know nothing but managed care, and expect to be employed most of their professional life," she noted.

Dr. Callan is well positioned to respond to physicians' needs at either end of the spectrum: she has worked as a medical practitioner as well as an administrative physician. A circuitous route took Dr. Callan from a physician to an administrator, and simultaneously from her homeland of Ireland to Connecticut, and finally to Illinois. From as early as she can remember, Dr. Callan wanted to be a physician. After all, medicine was in her genes; her mother was a doctor.

In Ireland, Dr. Callan became an anesthesiologist, earning her degree from the National University of Ireland in Dublin and serving her residency at Mater Misericordiae Hospital, also in Dublin. When her husband, Sean, who is a psychiatrist, was offered an opportunity in the United States, Dr. Callan accompanied him to Connecticut, where she became an anesthesiologist at St. Francis Hospital in Hartford. They planned to be in the United States for only a short time, but they have yet to return to Ireland.

Although she followed in her mother's footsteps, Dr. Callan vowed at a young age not to walk along the same career path entirely. As the only anesthesiologist for a 200-bed hospital, her mother had been on constant call, which cut deeply into the time she had for her children. Dr. Callan, on the other hand, left her job when her four children were young, to spend more time with them."Part of the reason that I stopped working outside the home is that I saw my children were acting the same way I did as a child when my mother had to leave for work," she said.

Dr. Callan stayed at home for several years to raise her children, sons Eoin, who today is a management information services specialist for The Hartford Insurance Company, and Colm, a venture capital expert for Merrill Lynch; and daughters Grainne, completing her masters degree in marketing at the University of Wisconsin, and Maeve, who has a fellowship at Northwestern University.

After those years with her children and a series of wide-ranging volunteer jobs, Dr. Callan was ready to resume her medical career. A call inviting her to enter the administrative side of medicine ended her practice as an anesthesiologist. For six years, she reviewed Medicaid eligibility claims for Connecticut's Department of Income Maintenance and then became the program's medical director, a role in which she supervised administrative policy and new programs.

In her current job as vice president of Abbott's Hospital Products Division, Dr. Callan is responsible for medical and regulatory activities for marketed and developmental products, as well as for identifying and developing new products. And as ISMS' first industrial physician to fill the president's seat, Dr. Callan said she will work to break down the mind-set that says only those who provide direct, hands-on care are doctors. "Growing numbers of physicians currently practice medicine in nontraditional ways, but they still are physicians," she said. "What's truly important is for physicians to unite and work toward common goals, instead of splintering. So much has changed for the worse following the advent of managed care, and it's time for physicians to take back their profession – something that can be achieved only with a collaborative approach."

Dr. Callan said that's

(Continued on page 10)

Clair Callan, MD

Andrew Corrigan Halpern

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EDITORIAL

Meet the new and improved ISMS

In some ways, organized medicine is much like a family: the backbone that holds you up when you are not strong enough to support your own weight; a united front that makes you stronger than you could ever be facing the world alone.

The need for a powerful physician organization has never been greater than in recent years, as physicians' authority in health care decision making has been diminished by managed care forces. But like a family going through troubled times, as organized medicine grapples to find solutions to this health care dilemma, tempers are sometimes quick to flare, and sadly there are some who have walked out and slammed the door.

Clearly, there must be changes in the methods organized medicine uses to serve physicians–and ISMS, for one, is ready and willing to make them. The Society's strategic planning committee labored for the past year to develop a plan for shaping a leaner, meaner organization that raises physician advocacy to the top of its agenda. In developing this plan, the committee listened carefully to the rank and file and also to the comments made by former members.

The plan was unveiled at the recent ISMS Annual Meeting, where it was given a stamp of approval by the House of Delegates. And, in a swift move to raise advocacy to new heights, delegates voted in favor of the Society's setting up a collective bargaining unit for eligible ISMS physicians. This bold break with tradition was just one more example that the new and improved ISMS is serious about responding to the needs of today's physicians.

Details of this makeover will be explained in the weeks and months ahead. Some committees will be restructured; some services will be curtailed to make room for other benefits our members have deemed more important.

This marks a new beginning for the Society. ISMS' incoming president, Clair Callan, MD, set the tone for the future by pronouncing physician advocacy as the organization's driving force.

A crucial element in implementing this plan is physician loyalty to the organization. Certainly, not everyone will always be in complete agreement about which direction is best to take. But at this juncture, it is crucial to remember that families – and associations – that thrive are those that stick together through thick and thin, not only in the good times but, more important, in the tough ones.

PRESIDENT'S LETTER

Wanted: Physicians ready to battle for a voice in health care

Clair Callan, MD

" . . . who do we want to speak for us, fellow physicians or managed care administrators?"

Once again the Annual Meeting is behind us and the new year has begun for ISMS. As your new president, I feel the need for ISMS unity has never been greater. There are many challenges facing us, but with your commitment and involvement, I believe we can achieve what is arguably our most important objective: regaining a controlling voice in health care.

To do this we need to concentrate on two things: membership and advocacy.

Advocacy has been identified as the most important activity for ISMS, labeled as such in both a survey that was conducted for the strategic planning committee and in exit interviews with those who have decided not to renew their memberships. We need more members who are willing to participate in an outreach program to physicians and legislators.

Membership is the cornerstone on which we will build our success. We have had a decrease in membership this year compared with last year. We MUST do whatever we can to stop this slide, encouraging every physician to join or rejoin ISMS. If we are to continue to have a strong voice with our legislators in Springfield, we must have a strong membership base. Numbers speak loudly to those who are elected.

After all, who do we want to speak for us, fellow physicians or managed care administrators? Do we want colleagues who understand the importance of the physician-patient relationship taking the lead in health care decisions? Or someone who is watching the bottom line and is concerned with the volume rather than the quality of care?

The answers to those questions are obvious, so I am reissuing the challenge I made to the House of Delegates at the Annual Meeting last month. Each one of us must be aggressive in recruiting a new ISMS member. Our job is to convince the nonjoiners, the fence sitters, that they are needed. We need their support, their commitment, as much of their time as they can give – and their financial backing as well.

My goal is to increase our membership by at least 25 percent this year. With your help, I know we can meet and even exceed that goal.

The second challenge I issued to the House of Delegates is for every member to "adopt" a legislator. There are several bills before the Legislature this year that should have physician input. This behind-the-scenes input, such as in a representative's office, can be very effective in laying the groundwork for decisions in the House itself. So please, start exercising your influence. Pick up the phone today and call your local legislator and offer to become a friend, a medical resource, a sounding board – whatever is needed. Here our voices might be softer, but they will be no less effective.

If all ISMS members make it a point to introduce themselves to their representative and senator, and offer to be a resource on medical issues, we will be providing an invaluable service to our state government, and reinforce our own expertise.

Medicine is our profession. We all worked hard to earn our medical degrees, which gave us both the knowledge and the skills needed to provide appropriate care. We alone have the special talents that are needed to make the best treatment decisions for our patients.

Let's make our voices heard, take back the right to be the decision makers, and start down the road to regaining control over medicine. Working together, we CAN do it. Please join me and the rest of YOUR leadership team. And let me know how you fare, with both membership recruitment and legislative contacts.

I am eager to accept all the responsibilities of the ISMS presidency, and look forward to forging a strong, communicative membership.

Medicare Part B carrier says transition "now behind us"

Last August, Wisconsin Physicians Service took over administering Medicare Part B claims for Illinois and Michigan. Illinois Medicine recently sat down with Stephen Boren, MD, medical director of Illinois Medicine Part B for WPS, to talk about the transition.

Q: Health Care Financing Administration officials predicted the transition from Health Care Service Corp. would "barely be noticed." How has it actually progressed?

A: The transition has gone very well and is now behind us. As one of the original Medicare carriers in the nation, WPS is not new to the Medicare business. I believe our transition went very well, for several reasons: the HCFA staff was exceedingly cooperative, WPS didn't make changes simply for the sake of making changes and the corporation had a strong commitment to the project. WPS is paying 99 percent of electronic claims and 98.5 percent of paper claims within 30 days – the HCFA standard.

Q: How is WPS handling the increase in workload?

A: WPS is now the largest Medicare carrier in the nation, based on volume. The corporation modified many of its systems and invested in technology to handle the increased workload; also, more staff were hired.

Q: In July, Renee Jackson of the WPS said the processing of new unique physician identification number (UPIN) certifications should return to an average length of time (45 days). Six months later, the process was still taking 70 to 90 days. What is being done about this backlog?

A: Every carrier in the nation will tell you the same thing: no one is able to process UPIN applications within the HCFA guidelines of 45 days. The application form is 17 pages long, and very complex. In fact, we are offering courses for office managers in how to fill the thing out. I'm not offering excuses; we are backlogged – there's no question. Unfortunately, it is apparently still taking WPS around 70 days to process new UPIN applications.

Q: Physicians who were requested to supply more information for their applications have complained that their forms get put at the bottom of the stack to be processed. How has that been addressed?

A: As long as physicians return their requests promptly, they don't lose their position in line. However, when doctors take weeks or months to reply, that's different.

Q: What can state medical societies do to help?

A: We have met with the state medical societies; we want any help they can give us. But I have no suggestions as to what they could do because I'm not the person who processes those applications.

Q: How are you planning to recruit more physicians to serve as consultants for medical reviews? Is there a role for medical societies to help?

A: I inherited a small number of consultants that my predecessor had used; I have also added a number of other physicians whom I personally know or who have been highly recommended by sources I trust.

I don't think the state medical societies can help find consultants for me because I have to use physicians with whom I am comfortable. Also, I will not use physicians from any state other than Illinois to review the records of Illinois doctors.

Q: How are standard Medicare policies being formulated? Is it possible that the policies of all three states will be melded into one-policy-fits-all?

A: I would love to have one policy fit all; it would make life a lot easier! Policies are developed by each state's Carrier Advisory Committee; it's likely that all three CACs will agree on a single policy for many procedures. However, there will be policy variations because of differing state laws and significant differences in regional practice patterns.

Q: Who has the final say about which policies will have variations?

A: The medical directors of each of the three states. If we all agree on a policy, it will be adopted for the three states; if we hit an impasse, then there will have to be variations. And if, for example, Wisconsin has a policy for a certain procedure and Illinois doesn't have one at all, then Wisconsin's policy will probably become Illinois' policy too. Even so, every policy has to go to the CAC before being adopted for the other states.

Q: Will the policies be posted on the WPS Web site?

A: Unfortunately, a CPT licensing issue has prohibited our efforts to even set up an Illinois WPS Web site. Although our policies currently are posted on the Wisconsin WPS Web site, it's possible that we will no longer be allowed to keep even that site. Until this licensing problem can be resolved, we're at a real impasse. ■

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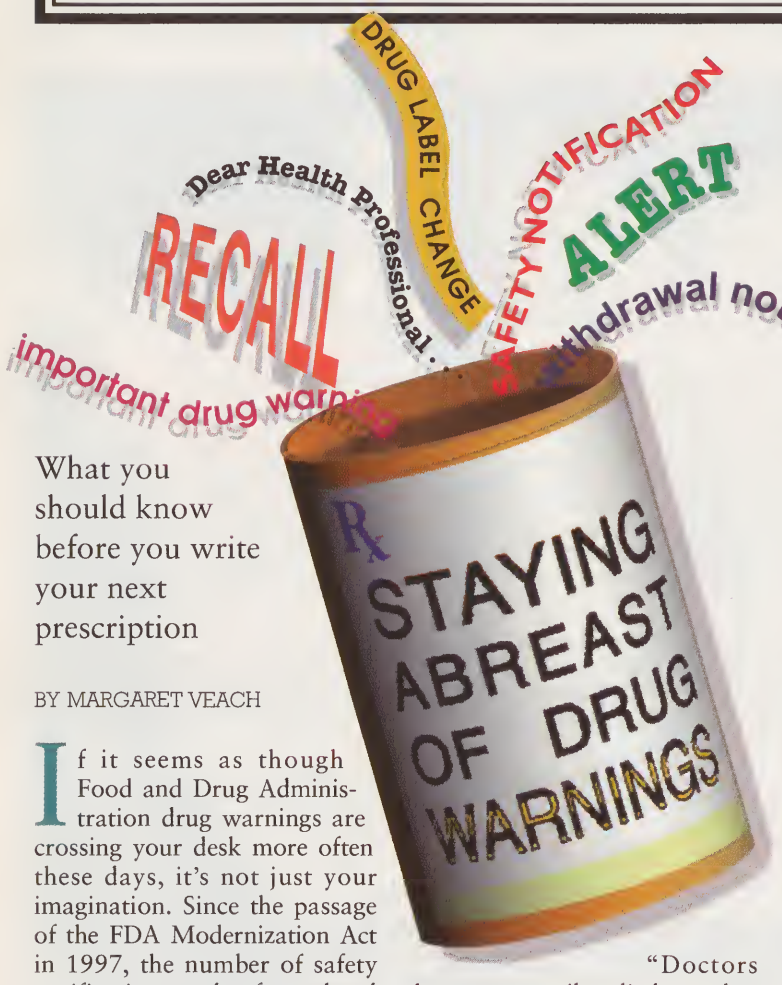

What you should know before you write your next prescription

BY MARGARET VEACH

If it seems as though Food and Drug Administration drug warnings are crossing your desk more often these days, it's not just your imagination. Since the passage of the FDA Modernization Act in 1997, the number of safety notifications and safety-related drug labeling changes has approximately doubled.

So how do physicians keep current with this deluge of information? "There is no easy way," admitted Ronald Gottrich, manager of Drugs and Medical Devices Programs for the Illinois Department of Public Health.

"Doctors have customarily relied on what they learn from drug company sales representatives, journal articles and package inserts," he said.

Additional sources are available, however. For one thing, the FDA mails its alerts to physicians, pharmacists, the media and others. Edward Langston, MD, a member of the ISMS Committee on Drugs and Therapeutics, recommends that physicians instruct their office staff to put those mailings directly on the physician's desk; Dr. Langston also keeps them in a file.

In addition, the United States Pharmacopeia Dispensing Information is a good source of peer-reviewed drug information that is updated yearly as well as with monthly supplements (volume 1 is written for health care professionals).

Gottrich relies on a particularly immediate source of drug information: e-mail. He subscribes to a free FDA service that notifies recipients by e-mail as soon as drug safety-related material is posted on the MedWatch Web site. To get on the list, send a subscription message to fdalists@archie.fda.gov. Enter the following in the body of the message: subscribe medwatch YourEmailAddress@YourDomain (replace "YourEmailAddress@YourDomain" with your own e-mail address).

Another good way to keep abreast of drug warnings is through the Internet. The FDA's primary Internet location for safety-related information is the MedWatch Web site (http://www.fda.gov/medwatch). Among other information, it contains FDA enforcement reports and constantly updated safety notifications such as public health advisories, safety alerts and letters to health professionals on all the products regulated by the FDA. Click on "Safety Information" for a list of the safety notifications issued since 1996.

Physicians can access the FDA's exact words on a particular drug through its World Wide Web site (http://www.fda.gov). To find the latest drug information from the FDA home page, use either the search feature or click on "What's New," then select "Other Press Releases, Talk Papers and Other Publications."

Also, the FDA's Center for Drug Evaluation and Research (CDER) and Center for Biologics Evaluation and Research (CBER) both have helpful sites for accessing safety-related information. CDER handles intravenous solutions and pill-form compounds. For a list of newly approved drugs, summaries of labeling changes related to drug safety, the weekly FDA Enforcement Report, and 38 other categories of drug-related information, go to the CDER Web site (http://www.fda.gov/cder/drug.htm). CBER deals with vaccines, blood and blood-derived products; among other useful information, its Web site (http://www.fda.gov/cber) includes a list of all blood products that have been recalled since 1997. ■

Alert, Recall, etc. – What's the difference?

The type of drug warning issued depends on the severity of the situation and the speed with which the information needs to get out, said Paul Richards, a spokesman for the Food and Drug Administration's Center for Biologics Evaluation and Research.

For example, product safety information sheets are early warnings about specific problems or products. "Dear Health Care Provider" letters include more extensive information and perhaps carry FDA recommendations about how to manage around the problem. In cases in which the FDA considers a drug or its manufacturing process to be in violation of the Food, Drug and Cosmetic Act, the agency issues warning letters to the manufacturer to ensure compliance.

Other kinds of warnings include alerts, important drug warnings, recalls, withdrawals and safety-related drug label changes.

DRUG WARNINGS: A heads-up on prescription risk

BY MARGARET VEACH

The second most frequent reason physicians are sued is for medication errors, according to a 1993 study by the Physician Insurers Association of America (the most frequent is missed diagnoses).

That's strong motivation for physicians to scan the Physicians' Desk Reference and other resources for warnings before prescribing a new or unfamiliar drug, said Kenneth Baker, vice president and general counsel for Pharmacists Mutual Insurance Co. Pay special attention to those printed in a black box, he advises. Boxed warnings indicate the drug can have particularly serious consequences if prescribed or taken incorrectly.

But once you learn of a warning, then what? There are situations in which a drug with a warning may be the best – or only – treatment for a particular condition. "In that case," said Baker, "the physician should take a risk assessment, asking, 'Is the risk for this patient of not using the drug outweighed by the risk of using it?' The answer could very well be yes. If so, your decision to prescribe is not necessarily negligent."

The New Jersey Supreme Court in 1998 underscored that point in a ruling in a medical malpractice case involving a prescription for quinolone given to a pregnant woman. Before prescribing, the physician had checked the PDR, which included a warning against using the drug in pregnant women unless the potential benefits of treatment justified the potential risk to the fetus. When the fetus died, the patient sued, claiming the emergency physician was negligent for ignoring the warning.

The state supreme court upheld the trial court's decision in favor of the defendant, stating that failure to adhere to a PDR warning does not in itself constitute physician negligence.

Nevertheless, FDA warnings must be taken seriously, said Baker. His advice is to document the entire risk assessment thinking process: "Write in the patient's record the pros and cons of prescribing the medication, that you are aware of the warning, that you discussed the risks with the patient and that the patient agreed with your treatment decision."

According to Ronald Gottrich, manager of Drugs and Medical Devices Programs for the Illinois Department of Public Health, pharmacists have a legal obligation to prospectively review a prescription before filling it, and to notify the physician if that review reveals any warnings, potential problems or drug interactions.

Unfortunately, said Baker, this discussion sometimes doesn't take place because physicians aren't always told that a pharmacist called about a prescription. "Instruct your staff that any time a pharmacist calls, you should be given the message," said Baker. "Your staff should never tell the pharmacist to go ahead and fill a prescription without talking to you first. Ideally, the physician should talk directly to the pharmacist.

"Also, a call from a pharmacist regarding a drug warning on a prescription you wrote should be documented in the patient's record."

Obviously, keeping in mind every piece of up-to-the-minute drug information is difficult, said Gottrich. "The information overload simply emphasizes the need for continual, professional communication between the physician and the pharmacist."

Julia Anderson-Miller

Legislative victories pile up

BY PAULA KRAPF

In addition to ongoing advocacy for key legislation, ISMS also recognizes the importance of countering bills that champion laws potentially detrimental to the interests and well-being of Illinois physicians and patients. To that end, ISMS has successfully opposed approximately 100 bills within the past year.

However, this is no time to rest on laurels, because bills ISMS opposes could be resurrected at any time, said Nestor Ramirez, MD, Chairman of ISMS' Governmental Affairs Council. Continued vigilance is required.

ISMS' legislative agenda is developed from policies adopted by the ISMS House of Delegates, with the input of other ISMS councils and committees, said Dr. Ramirez. The Board of Trustees approves specific positions, and then ISMS fights hard to turn the Society-approved bills into law and to defeat the bills it opposes, he said.

ISMS-opposed bills that have been stalled in committee or on the floor of the House or Senate during the current legislative session include the following:

• Clinical psychologists prescriptive authority legislation would have allowed certified clinical psychologists to prescribe and dispense drugs and medicine. ISMS does not believe clinical psychologists have the training or experience necessary to exercise this authority. H.B. 1736 was sponsored by Rep. Carol Ronen (D-Chicago).

• Marriage/HIV testing legislation would have required couples to have syphilis and HIV tests performed not more than 30 days before applying for a license. ISMS feels this bill produces unnecessary government regulation as well as additional costs for couples who want to marry. S.B. 889 was sponsored by Sen. Kirk Dillard (R-Hinsdale).

• A physician fee-disclosure proposal would require physicians to disclose the amount of the charges, which must be at least equal to 90 percent of final charges, before requesting authorization by the patient for a treatment plan. ISMS notes that charges are difficult to predict prior to treatment, and this bill placed an unreasonable administrative burden on physicians. S.B. 470 was sponsored by Sen. Steven Rauschenberger (R-Elgin).

• Physician billing prohibition legislation would have limited physicians and health care providers to billing enrollees or insureds only for copayments, deductibles and fees for services not covered. The Society contended that this bill would prevent physicians from billing patients for the balance of services that HMOs don't cover. Nor would it let physicians charge patients for services not covered by the HMO. S.B. 471 was also sponsored by Rauschenberger.

• A proposal that would have allowed the two members representing the public on the medical disciplinary board to become voting members failed. ISMS believes that only physicians' peers should make final disciplinary recommendations to the director of the Illinois Department of Professional Regulation. H.B. 913 was sponsored by Rep. Eileen Lyons (R- Western Springs).

• The Hypnotherapist Licensing Act would regulate the practice of hypnotherapy through licensing requirements. ISMS opposed the bill on the basis that individual treatment modalities should not be licensed. H.B. 503 was sponsored by Rep. Jerry Mitchell (R-Sterling); S.B. 68 was sponsored by Sen. Todd Sieben (R-Geneseo).

• The Medical Fraud Enforcement Act would require fines imposed for medical fraud to be deposited into a special Medical Fraud Enforcement fund for use by the Attorney General. ISMS opposed the bill because it defined billing errors as medical fraud. S.B. 754 was sponsored by Rauschenberger.

• Medical lien claims legislation would limit liens to one-third of an award, which ISMS believes reduces the chance of a physician receiving payment. H.B. 232 was sponsored by Rep. Thomas Dart (D-Chicago); S.B. 1149 was sponsored by Sen. Dan Cronin (R-Elmhurst). ■

The countdown begins

There are only about two weeks left to press for support of important bills ISMS is working to pass in the current Springfield legislative session.

Important dates ahead include:

➥ May 7: Senate deadline for voting House bills favorably out of Senate committees to reach a vote on the Senate floor.

Bills not passed out of committee by the deadline will die. (House deadline to pass Senate bills out of committee was April 30.)

➥ May 14: Senate deadline for passage of House bills; House deadline for passage of Senate bills.

➥ May 18-21: Joint House-Senate conference committee sessions to work on compromise legislation.

➥ May 21: General Assembly adjourns.

To learn the names and numbers of legislators representing your area, and which pending bills need support, call ISMS' Division of Governmental Affairs, (800) 782-4767, Ext. 1142.

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Dr. Callan

(Continued from page 3)

where her business and administrative skills come in. "I know how to get groups to compromise." Her first taste of bargaining occurred while she was administering Connecticut's Medicaid program and she had to bring the physician side and the business side of medicine together. Dr. Callan said doctors' initial skepticism was broken down once she invited them to participate in the planning process.

ISMS' ongoing communication with the Illinois Society of Anesthesiologists to pass legislation licensing certified registered nurse anesthetists is a shining example of how specialty societies and ISMS can work together. United, they achieved something that neither group could accomplish on its own, she said.

The unity theme extends to ISMS' relationship with the American Medical Association, which has been strained in recent years. Dr. Callan believes that state and national groups must work hard on communicating better and more frequently. But regardless of the recent AMA accountability troubles, Dr. Callan, whose AMA affiliation began in the late 1970s, believes physicians need a strong national umbrella organization. "The AMA taught me the value of being involved in the political process," she said. Moreover, Dr. Callan's experience working for the state of Connecticut taught her the value of knowing how to make the system work in order to get things done – a fact she believes many physicians do not fully understand.

Dr. Callan sees her participation in medical politics as a vital method to help improve physician practice environments on a national as well as state level. In 1986 she joined ISMS, where her involvement has included service on the Governmental Affairs Council, Council on Public Relations and Membership Services, Committee on CME Accreditation and as an AMA delegate.

Advancing ISMS' legislative agenda will be another of Dr. Callan's priorities, whether by continuing the fight for a comprehensive patient rights law, improving physician-payer terms, ensuring that health plans are responsive to patients and physicians, or responding to other issues that members raise.

The membership is eager for legislative action, Dr. Callan observed, so Springfield victories will work hand-in-hand with her first priority: membership retention and recruitment. "We need members to talk to us about that agenda so we can be sure that we're truly advocating for them and getting the right message across," she said.

For Dr. Callan and for ISMS, the year ahead is clearly full of opportunities. As the new ISMS president, she is rightfully anticipating the challenges that await. Her conviction and optimism suggest a strong year for ISMS initiatives. "Failure," she concluded, "is not an option." ■

Calling all ISMS residents and fellows!

The ISMS Resident and Fellow Section is looking for members to contribute to ISMS' policy and decision-making endeavors. Residents and fellows interested in heightening their participation in the Society are encouraged to apply for a council or committee position.

Get in touch today; share your knowledge and experience to help all Illinois' patients and physicians. Call ISMS-RPS for information at (312) 782-1654 Ext.1272, or e-mail rps@isms.org. Applications will be accepted until Monday, May 17. ■

HIV reporting workshops to be held statewide

Effective July 1, physicians and other health care providers will be required to report cases of HIV infection as well as AIDS to appropriate local health jurisdictions by means of a specialized patient code number.

Training sessions on the new case-reporting efforts began in late April and will continue through May and June. For a registration brochure or more information, contact the Midwest AIDS Training and Education Center at (312) 996-4429. Following are the remaining May sessions; June workshops will be listed in a future issue of Illinois Medicine.

May 11,* Chicago
Illinois Masonic Medical Center
May 12, Rock Island
Rock Island County Health Department
May 20, Rockford
U. of Illinois College of Medicine
May 25, Peoria
U. of Illinois College of Medicine
May 26, Glen Ellyn
College of DuPage

* This workshop is being presented by the Chicago Department of Public Health, and is intended only for Chicago health care professionals. ■

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1999 Sites & Dates

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Hilton

June 16 • Wed — ***Bloomington***
Jumer's Hotel

June 17 • Thurs — ***Lisle-Naperville***
Radisson

October 5 • Tues — ***Springfield***
Hilton

October 6 • Wed — ***Chicago***
Courtyard by Marriott

October 7 • Thurs — ***Joliet***
Holiday Inn

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- ❑ **Bloomington — Wed • June 16**
- ❑ **Lisle-Naperville — Thurs • June 17**
- ❑ **Springfield — Tues • October 5**
- ❑ **Chicago — Wed • October 6**
- ❑ **Joliet — Thurs • October 7**

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KidCare

(Continued from page 1)

difficult because many of them do not receive public aid and are not familiar with state assistance programs.

To quantify the number of children who could be served by KidCare, the University of Illinois at Chicago will conduct a survey in May. Those numbers will be used to measure the success of the KidCare enrollment initiative, Patla said.

ISMS will contribute to the enrollment effort by publicizing KidCare to its members, said ISMS Immediate Past President Richard Geline, MD. "The important thing is ensuring Illinois children get the health care they need," he said.

Gov. George Ryan is also committed to increasing KidCare enrollment for children. "If we can get health care services to children at an early age, they will need less care as they grow up," Ryan said during an April 12 news conference.

The promotional blitz currently under way includes the following measures:

• Physicians, hospitals, health departments and clinics will receive a $50 technical assistance fee for every approved application that results in a new KidCare enrollee. (Physicians who are willing to serve as KidCare brokers should contact the IPDA at (800) 226-0768 to obtain forms, training and direction in properly completing KidCare applications.)

• Radio spots, transit billboards, television ads and additional mass-mailings will promote KidCare.

• Grassroots endeavors will have churches, labor unions, chambers of commerce and employers distributing KidCare information to eligible families. For instance, The Pastors Network, which includes 127 churches in the Chicago area, has agreed to provide KidCare information to qualified congregants.

• Community organizations that work with immigrant populations will receive KidCare information to disseminate.

• State agencies such as the Department of Revenue, Secretary of State's Office, Department of Employment Security, and the Department of Children and Family Services will display posters, mail flyers and use other means to draw attention to KidCare.

• The Chicago Public School system has mailed information to more than 200,000 families who may qualify for KidCare because they are enrolled in the free/reduced lunch program; those families can drop off the application when they pick up their child's report card.

Furthermore, IDPA has simplified the application form from nine pages to two, easing the bureaucratic red tape that may be preventing many families from joining. IDPA also has increased its processing staff from 12 to 95 to reduce enrollment time.

To keep KidCare in the public eye, many of the publicity approaches will be repeated and new promotional campaigns developed every six months, Patla said. "Our goal by year's end is to at least double the number of KidCare enrollees we currently have," she said. ■

Strength in numbers

(Continued from page 1)

want CMS to form a union, Dr. Murphy added.

A collective bargaining unit would address the pressing needs of younger physicians, said medical student Sharyl Truty. "This is what your younger members want," she said.

The floor vote overrode a recommendation by the reference committee that the matter be referred to the Board of Trustees for research and analysis before moving ahead. "We need to work out the mechanism of how this will take place," said delegate David Loiterman, MD, who preferred referring the issue to the Board of Trustees.

But supporters argued for immediate action and said forming a collective bargaining unit would demonstrate to Society members that ISMS wants to lead physicians in their drive to break free of the constraints placed on them by insurance companies, the government, managed care organizations and hospitals.

The House of Delegates action is consistent with Society policy, which supports collective bargaining as a valuable method for maintaining control of the practice of medicine to ensure quality care to patients and fair reimbursement for physicians' services. Current labor law limits membership in collective bargaining units to employed individuals, and before proceeding, the Society must determine how physicians fit into that definition, said ISMS General Counsel Saul Morse.

Delegate Steven Malkin, MD, encouraged ISMS to look also to the American Medical Association for assistance because the Association is forming its own bargaining unit. The AMA's House of Delegates will vote on the proposed American Medical United collective bargaining unit for employed physicians at its Annual Meeting in June.

Such a far-reaching initiative must be tackled with care, cautioned Peter Orris, MD, a delegate from the Third District who backed the resolution. "We are doomed to failure if the impetus is solely economic. Our banner must be good health care." ■

ISMS stays unified

(Continued from page 1)

two-thirds vote needed to delink. However, the subsequent ballot also failed, falling nine votes short of a two-thirds majority.

Deunification has been on the House agenda almost annually during the past two decades. Each time the vote tally has inched closer to ending the Society's unified status and giving members the right to decide on their own if they want to belong to the AMA. The most recent deunification vote occurred at a September 1998 House of Delegates special meeting, in which members voted 81-80 in favor of deunification. The resolution failed, however, because it received nowhere near the two-thirds majority needed to change the Society's bylaws. After that meeting, ISMS and the AMA's leaders discussed the Society's dissatisfaction with the AMA. The AMA's leadership pledged to turn the organization around in one year.

Prior to this latest deunification debate and vote, the AMA's Vice Speaker, John Knote, MD, asked ISMS members to keep their faith in the AMA because the organization was struggling to earn their membership every day. "It takes time to turn a battleship around, and we have been traveling in some rough waters. I see calmer waters ahead," Dr. Knote said.

The Society's surveys have revealed that 63 percent of ISMS members and 81 percent of nonmember Illinois physicians desire deunification, and the majority of physicians who recently canceled their memberships strongly suggested that ISMS deunify.

The reference committee that met to consider the deunification resolution recommended that delegates vote to terminate ISMS' unified status. "Allowing Illinois physicians the freedom to belong to the medical society of their choice is the prudent course of action and in the best interest of sustaining and growing ISMS membership," said James Ahstrom, MD, chairman of the reference committee.

ISMS is clearly not attracting younger physicians, the majority of whom favor deunification, said Arthur Traugott, MD, chairman of the ISMS Board of Trustees. "Do we want ISMS to survive and grow?" he asked. "As we've learned in our practices, the status quo is no longer a viable option."

Voting for deunification does not mean that ISMS will abandon the AMA, said Edward Warren, MD, a delegate from Vermilion County. "Our fate will be separated somewhat [from the AMA's], and we hope that we'll be able to do a better job as an independent organization," he said.

Previously a unification champion, Richard Snodgrass, MD, ISMS' 1st vice president, said he has had a change of heart. "We need to keep ISMS viable ... [unified status] is something around our neck that could hinder us from doing that."

ISMS members who prefer to remain unified said all segments of organized medicine must be allied to overcome the onerous burdens of managed care.

"We need to have a national body to represent our interests in Washington, D.C.," said Shastri Swaminathan, MD, a Third District delegate. Although he believes the AMA has performed abysmally of late, Dr. Swaminathan said ISMS must give the AMA leaders the year they requested to chart a new course for the association.

Many younger members aren't joining organized medicine because they are employed physicians, said Edmund Donoghue, MD, a member of the ISMS Board of Trustees. "To attract younger physicians, ISMS must advocate for issues that count to this group, such as collective bargaining," he said. "The AMA is already pursuing that matter, and ISMS should join the AMA's effort. I think we should stay connected to the AMA."

Following the unity debate, Dr. Traugott emphasized that ISMS has launched a new era that will reach out to young physicians and longstanding members alike. "The organization has rededicated its energy toward physician advocacy," he said. One of those steps, approved at the recent Annual Meeting, is to develop a collective bargaining unit. In addition, this turning point includes a heightened member advocacy effort to intervene in the business arena to help resolve problems between physicians and third-party payers, government agencies and others imposing hassles on physicians, he said.

"We are tied to the AMA ... it is wrong for us to break that tie," said Janis Orlowski, MD, secretary-treasurer of ISMS' Board of Trustees and president of the Chicago Medical Society. Moreover, the AMA is doing everything ISMS has asked of it, including reducing dues as well as holding regular staff and leadership meetings between ISMS, the Chicago Medical Society and the AMA. Furthermore, ISMS needs the AMA because the Society's newly adopted strategic plan calls for the AMA to provide for certain services previously paid for by ISMS.

Although deunification didn't occur as he had hoped, Dr. Osborn said his delegation will begin working again for a consensus on deunification at the district caucus level. Meanwhile, he will take to heart the advice given by ISMS President Clair Callan, MD, during her inaugural speech. "The three points Dr. Callan made: to be involved in ISMS, to recruit new members and to adopt a legislator ," he said. ■

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(See stories below)

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MAY 21 1999

Medical records blues

PAGE 6

SPRINGFIELD REPORT

Prompt-pay bill passes

ISMS leads the way to speedier reimbursements

BY PAULA KRAPF

Physicians could find their claims check in the mail, pronto, now that an ISMS-generated prompt payment bill has essentially passed the Illinois General Assembly. As Illinois Medicine went to press, the legislation was expected to land soon on Gov. George Ryan's desk.

The bill had one detail to undergo – it had passed the House and Senate and required House concurrence on a subsequent amendment.

A consensus-building process led by ISMS and including representatives from the HMO industry, insurers and hospitals led to a prompt-pay bill that all sides could endorse. H.B. 2713 would require the following:

• Once a physician or other health care practitioner files a due proof of loss, insurers and health maintenance organizations have 30 days to pay the claim.

• Failure to make prompt payments would generate a penalty of 9 percent interest that begins on the 31st day and continues until payment has been made. The payments will be automatic, and the physician will not have to bill the insurance company or HMO to collect that money.

• Until 2001, independent practice associations and physician hospital organizations would have 60 days to pay claims. Then IPAs and PHOs must meet the 30-day payment requirement.

• If a claim is not clean, the insurer, HMO, IPA or PHO has 30 days to notify the physician or health care practitioner of the error. The organization also must explain how the doctor or practitioner should rectify the mistake.

• For capitation payments, the payer has 60 calendar days to notify the physician or other practitioner that a patient has selected him or her. The payer also must let the practitioner know the date that the selection takes effect. The initial capitation payment must occur within 60 days of the effective date, and subsequent payments must be made monthly.

Credentialing bill moves forward, too

As Illinois Medicine went to press, ISMS was actively seeking a bill that would eliminate the credentialing hassles and duplication that physicians currently face.

Negotiations between ISMS and insurers, HMOs, hospitals and credentialing verification organizations were still under way. H.B. 1780 was passed by the Senate and was awaiting the endorsement of the House. In its current form, the bill includes the following:

• The Illinois Department of Public Health would develop a standardized credentials form to list a physician's core credentials data. A physician would fill out the form only once, then any organization he or she seeks credentials from would receive copies of that form. ■

Ron Ackerman

ISMS President Clair Callan, MD, (right) explains the need for a patient rights law to Rep. Susan Garrett in Springfield.

Reform crusade down to the wire

mission:

MCPRA

ISMS' drive to see a patient rights bill become law continues unabated as the 91st session of the General Assembly draws nearer to a close.

As Illinois Medicine went to press, ISMS was working closely with Gov. George Ryan, key House legislators and other health care organizations to fine-tune its patient rights legislation, S.B. 579, which passed the Senate but has not yet been voted on by the House. The negotiating parties are discussing possible amendments and remain hopeful that a compromise can be forged prior to the Legislature's adjournment.

In a further effort to keep this and other pending legislation alive, the May 14 deadline for the House and Senate to approve all bills was extended by one week. The General Assembly also may extend its session, which was slated to finish May 21.

Go online at isms.org for updates.

Annual Meeting followup: reaction to deunification, collective bargaining votes

AMA link continues, but many physicians still seek a split

BY PAULA KRAPF

After spending nearly a decade fighting for ISMS to deunify from the American Medical Association, Larry Jones, MD, called it quits this year. He resigned his ISMS membership in March and will not rejoin the Society unless deunification occurs.

Dr. Jones, who is a family physician in Harrisburg, believes physicians should have a choice about which organizations they join. "The state society has no right to require that its members belong to a separate organization," he explained. His sentiments are shared by a half dozen other physicians who practice with him at the Primary Care Group, who he said would rejoin ISMS if it deunified.

John McNulty

Craig Backs, MD

For AMA unity opponents, frustration reached a head after the April 24 ISMS House of

(See Deunification, page 13)

Physicians seek joined forces as a way to fight managed care BY PAULA KRAPF

As word that ISMS will attempt to form a collective bargaining unit rapidly spread, gratified physicians hailed the decision as a sure sign that ISMS will aggressively advocate for its physicians by tackling managed care's many abuses.

"Purely for-profit medicine at the expense of the physicians and the hospitals has to end," said Long Grove pediatrician William Rutenberg, MD. Physicians are the "lambs who are thrown to the wolves of managed care," he said, and a collective bargaining unit could level the playing field for physicians and payers by working to ensure that physician reimbursement rates are fair and that patients receive quality care.

Gurnee general surgeon Richard Furman, MD, agrees with Dr. Rutenberg. "We have no control over the practice of medicine because insurance companies are practicing medicine without a license," he

(See Bargaining, page 14)

INSIDE

A helping hand

U.S. Senator pledges to support physician battle against managed care perils

BY PAULA KRAPF

U.S. Sen. Richard Durbin (D-Ill.) recently witnessed firsthand the frustrations physicians face daily under managed care. The senator had been assigned to spend the day with a Sangamon County physician as part of the county medical society's mini internship program that pairs lawmakers with doctors to educate community leaders about health care issues.

As Durbin looked on, the physician spent more than an hour arguing with an insurance clerk over a patient's treatment. The patient – slated for brain surgery in two days – was experiencing symptoms that the physician believed warranted her immediate admission to the hospital. Yet the insurance company firmly told the doctor to send the patient home.

John McNulty

Sen. Richard Durbin

The incident is not an isolated case, Durbin acknowledged during an April 24 speech at the ISMS public affairs breakfast, a yearly event held during the ISMS House of Delegates Annual Meeting.

"As I go around the state and listen to physicians who tell me what they have to put up with to exercise their professional judgment in the care of patients, it is frightening," said Illinois' senior senator.

Durbin said such cases unquestionably demonstrate that federal and state patient protection laws must pass quickly. His statement was greeted by hearty applause.

Durbin spoke on several additional health care-related topics.

Collective bargaining. Durbin said he understands the sentiment of many doctors who are saying they have to come together. If organizing such collective bargaining units violates existing federal antitrust laws, Durbin vowed to work with physicians to change those laws.

Medicare fraud and abuse initiatives. Durbin defended the Health Care Financing Administration's effort to weed out fraudulent Medicare billing practices that recently drew fire from organized medicine when it solicited senior citizens to report suspected billing errors to the government. "If the patients aren't asking the questions, many times we don't ferret out serious errors that cost the system literally millions of dollars," Durbin noted. He encouraged physicians who have complaints about the program to contact him so he could go to bat on their behalf.

Declining Medicare reimbursement rates. The proposed Democratic budget would set aside 15 percent of the federal surplus for Medicare, extending the program until 2020 and ensuring there are no onerous reimbursement cuts, Durbin said. The proposed Republican budget would provide a tax cut for taxpayers. "That's the tradeoff: whether or not you're going to have the substantial tax cut, or put the money in Medicare. You have to decide individually and collectively whether this is worth the fight," he said.

Health insurance. "We have to expand the pool of those who are covered with health insurance," said Durbin. He has introduced a bill to create a small business tax credit to provide health insurance for lower-income employees. He also advocates making sure that self-employed people have the same deductibility for health insurance premiums as those working for corporations. Durbin also encouraged ISMS members to sign up eligible children for KidCare, Illinois' insurance program for low-income children.

Gun control. In the wake of the tragic shootings April 20 at Columbine High School in Littleton, Colo., Durbin reminded physicians that ISMS can make a critical difference in the debate on guns. There are bills in both Springfield and Washington to prevent children's access to firearms; they include the federal Children's Gun Violence Prevention Act of 1999 that Durbin cosponsored, which currently sits before the Senate Judiciary Committee. The bill would require gun owners to place trigger locks on their guns and store them in a locked site.

The tobacco settlement. Illinois will receive approximately $9 billion as the result of joining 41 other states in filing lawsuits against the tobacco companies. A substantial portion of the fund should be earmarked for health programs, Durbin said. "It makes me nervous when I read about governors across the country who have their eye on this money to build highways, or new state capitols."

Asthma. "I'm just stunned that Illinois has the highest asthma death rate among African-American males in any state in the nation," said Durbin. He sponsored the Children's Asthma Relief Act of 1999 to set aside $50 million for community and public health groups to develop innovative ideas for treating asthma and providing asthma education. The bill has been sent to the Senate Committee on Finance.

Durbin has also been a leader in the fight to change the federal ERISA law that exempts most health insurers from legal accountability for their medical decisions. Last year he introduced a bill that would make health insurers liable for bad medical outcomes brought on by their management of care. Although it failed to pass, the language in that bill has been resurrected in the Democratic Patient Bill of Rights currently pending in Congress. ■

Effort to kill immunization bill succeeds

Legislative UPDATE

A coalition that included ISMS mobilized and successfully thwarted an immunization bill that would have given parents the right to oppose mandatory immunizations for children based on the parents' conscientiously held beliefs.

Physicians pleaded with members of the House Human Services Committee to kill the bill because unvaccinated children leave themselves and other children susceptible to diseases that could be easily prevented by vaccinations.

Examples of preventable disease outbreaks among nonimmunized populations include 141 pertussis cases in Illinois in 1997, said Mark Rosenberg, MD, president-elect of the Illinois Chapter of the American Academy of Pediatrics and an ISMS member. Nine children have died of pertussis since 1993, and most of those cases were caused when infected children had contact with unprotected siblings or other children who had not been age-appropriately immunized, he said.

Before vaccines, millions of children contracted diseases such as polio, measles and tetanus, but since the introduction of vaccines, most of those diseases had been virtually eliminated, Dr. Rosenberg added.

After hearing both sides' impassioned arguments, on April 28 the Human Services Committee voted 11-1 to kill the bill. A month earlier, the bill had earned overpowering Senate support, passing with a 46-10 vote following emotional testimony from the bill's proponents. They noted that vaccines have caused disabilities, chronic illness and death.

Besides ISMS and ICAAP, the coalition included the Illinois Academy of Family Physicians, Illinois Association of Public Health Administrators, Illinois Maternal and Child Health Coalition, Chicago Department of Public Health, Illinois Public Health Association, Illinois Association of School Nurses and Voices for Illinois Children. ■

It's medical license renewal time

Illinois medical licenses and controlled substance licenses will expire on July 31. License renewal notices were mailed by the Illinois Department of Professional Regulation during the week of May 10. Physicians who did not receive a renewal notice should contact IDPR (see below).

CME requirement for medical license renewal

To renew Illinois medical licenses on July 31, physicians will be required to have earned 50 hours of continuing medical education between July 1, 1997, and July 31, 1999. Of those 50 hours, at least 20 hours must be in Category 1 (formal) CME and the remaining hours may be in Category 2 (informal activities, such as journal reading, publishing articles, etc.).

Proof of CME completion will not need to be submitted with the renewal form. Instead, the IDPR will randomly audit a percentage of renewed physicians, who will then be required to submit the appropriate CME documentation.

Physicians may request a waiver of CME requirements for reasons of extreme hardship such as an incapacitating illness or full-time military service. Waiver requests must be submitted to IDPR in writing with the renewal application and will be reviewed by the Medical Licensing Board.

Physicians who are renewing their license for the first time are not required to have completed the required CME.

For further information, please contact the IDPR at (217) 782-0458, or e-mail queries to question@dpr084r1.state.il.us. E-mail queries will be answered within 24 hours. Information, including address changes, and requests can be faxed to IDPR at (217) 782-7645. Commonly asked questions are answered on the IDPR Web site at http://www.state.il.us/dpr ■

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EDITORIAL

Good news is no accident

There is much to cheer about in the legislative victories ISMS has achieved in the General Assembly this session that hold great promise to empower and protect physicians and patients.

Legislative successes do not happen by accident. Look behind any legislative cause that has succeeded in recent history and you will find a strong lobbying organization. Shaping legislation in Springfield is a top ISMS priority. The process begins with input from ISMS councils and committees. Policies are then adopted by the House of Delegates, which sets in motion the Society's fight either to turn its legislative goals into law or to defeat bills it opposes.

Successful outcomes in the General Assembly also take members' support, both financially and through development of personal relationships with legislators. ISMS President Clair Callan, MD, has challenged each ISMS member this year to "adopt" a legislator. By developing a relationship with a Senator or Representative, ISMS members can share their viewpoints with legislators firsthand and explain how the laws being considered will impact physicians those legislators know personally.

One victory emerging from this legislative session is a bill on the way to the governor's desk that protects physicians from unfair treatment by hospital boards. The bill allows the boards to be sued for decisions found to be wilful or wanton – a change from the complete immunity they now hold.

Another bill that passed the House and Senate mandates that when a physician's medical staff application is denied, the hospital board must give written notice telling the physician why. The bill also requires hospital boards to seek medical staff input before they stop accepting new medical staff applications.

There is likely more good news to come. At press time, a bill to ensure that physicians are promptly paid by insurance companies and a bill to reduce credentialing hassles were being negotiated. Also, we remain optimistic that a new Managed Care Patient Rights Act will become law this year.

Victories also have been racked up in the defeat of proposed legislation that would have been deleterious to physicians and patients. One such proposal would have made it easy for parents to opt not to have their children immunized with the vaccines required by state law.

Also killed were a proposal to limit medical lien claims to one-third of an award, which would reduce the chance of physicians receiving payment, and a bill that would have prevented physicians from billing patients for the balance of services that HMOs don't cover.

ISMS has a great track record in Springfield of protecting physicians' and patients' interests. But that's no reason to rest on past performance. Call ISMS' Division of Governmental Affairs, (800) 782-4767, Ext. 1142, to learn how to take an active role in the legislative process.

PRESIDENT'S LETTER

ISMS collective bargaining shot heard 'round the world

Clair Callan, MD

The action taken by the ISMS House of Delegates on April 25 to direct the Society to develop a collective bargaining unit was heard far and wide. To many people, collective bargaining automatically means a "union."

But for physicians, what it really means is that we are sending a clear message that we demand to be heard on clinical decisions and health care issues; that we have a powerful voice and we are going to use it. Our members and many nonmembers are pleased that we are taking a strong stand on this issue.

Most of the feedback we have received has been very positive. The media response has been quite intense. I have spoken with reporters from across the country, including some from Washington, D.C., and from a variety of media outlets, including radio news people and writers from several health care publications.

> *"The more members we have, the stronger our voice will be."*

My message has been consistent: physicians will be heard. We are the ones who know the best treatment approach for our patients; we are the ones who should play a role in deciding how health care should be delivered. We will continue to emphasize this.

One of the challenges I extended during the Annual Meeting was for every member to recruit at least one new member to join ISMS. I know that some of you were disappointed that the deunification vote did not pass. But we can't let that stand in the way of getting new members. We need numbers. The more members we have, the stronger our voice will be.

The fact that we did not deunify may make it more difficult to get nonmembers to join, but I hope that you can persuade them that we need them now. The collective bargaining issue is just one of the important issues we are dealing with; we need help in many areas.

Another challenge I issued at the Annual Meeting was for every member to adopt a legislator. My adoptee, Rep. Susan Garrett (D-Lake Forest), is brand new to the Legislature but already is making her voice heard. She is a member of the House Health Care Availability and Access Committee.

I went to Springfield April 27 to testify before that committee in support of S.B. 579, the Managed Care Patient Rights Act. To the dismay of both the committee members and the public, the committee chairperson refused to allow any testimony to be heard, or to call the bill for a vote.

Despite that disappointment, I took advantage of the opportunity to meet with several legislators to express the importance of passing a comprehensive patient rights bill now, even if it does not include all the components that advocates would like. We can continue to work on this, but we must get a law on the books immediately.

As we go through the coming year together, I want to know how you are doing with the three challenges I issued last month when my term as president began. Those challenges are to get more involved in ISMS, recruit at least one new member to the Society, and adopt a legislator.

Write, call or e-mail (callan@isms.org) me to let me know if there is anything we can do to help you meet each of these challenges. ISMS is your organization. The leadership needs your help to make this the most effective organization it can be.

BATTLE PLANS

"The House of Delegates . . . shall set the basic policy and philosophy of the Society."

– ISMS Constitution

ISMS agenda leads the fight for physicians, patients

Looking out for the rights of physicians and protecting patients were recurring themes of many resolutions approved by the ISMS House of Delegates at its April 23-25 Annual Meeting. Besides support for forming a collective bargaining unit and seeking caps on malpractice awards, delegates gave the go-ahead to pursuing several other initiatives that advocate for physicians and patients.

Physician advocacy:

Medicare fraud and abuse:

- ISMS will ask the American Medical Association to work to abolish the federal government's Medicare fraud and abuse initiative and vigorously oppose the establishment of any national fraud and abuse databank for health professionals who participate in Medicare.
- ISMS will develop an advocacy program to assist members with education on Medicare billing and reimbursement and provide business assistance.
- ISMS will document any abusive fraud and abuse incidents against physicians.

Credentialing:

- ISMS will encourage and promote the development of a standardized, universally acceptable form for the routine information physicians submit for credentialing.
- ISMS will endorse the creation of a central credentials verification entity to eliminate duplication and repetition.

Prompt payment of claims:

- ISMS will support legislation that requires all managed care organizations to pay claims in a timely manner.

Late claims penalties:

- ISMS will request that the AMA take steps to reverse the Health Care Financing Administration's policy of automatically imposing a 10 percent penalty on claims submitted more than one year after the date that services were provided.

Legislative mandates:

- ISMS will study all legislative mandates for health insurance and support only those that protect patients and do not increase the number of uninsured people in the state.

Physician entrepreneur activity:

- ISMS' new policy states that members will not coerce patients to purchase medications, vitamins, nutritional supplements or medical devices or participate in marketing programs in which physicians profit from their patients.
- ISMS will submit this policy to the AMA House of Delegates for adoption as AMA policy.

Hospital medical staff:

- ISMS will advocate for medical staff members, investigate their complaints and, if necessary, remind the hospital that medical staff bylaws are a binding contract between the medical staff and the hospital organization.

ISMS-IMG Section:

- ISMS approved goals and bylaws for the International Medical Graduate Section, which was established at the 1998 Annual Meeting.

Patient advocacy :

Automated external defibrillators:

- ISMS will continue to lobby for a law governing the availability of automated external defibrillators.

Generic drug pricing:

- ISMS will ask the AMA to review the sudden and significant rate increases in the generic drug industry with the American Pharmacy Alliance, trade associations representing generic drug manufacturers and other appropriate entities and alert the appropriate federal agency of any inappropriate marketing, dispensing or incentive practices.

Prescription drugs:

- ISMS will encourage the pharmaceutical industry to discontinue mass advertisement of prescription drugs and pass the savings to patients.
- ISMS will ask the AMA to approve a similar resolution at its June Annual Meeting.

Screening for domestic violence:

- ISMS will support private and public entities' projects that are designed to prevent domestic violence, including physician screening for domestic violence.

Safety at railroad crossings:

- ISMS will explore ways it can support and promote safety at crossings, including helping the Illinois Department of Transportation study railroad crossing safety and asking IDOT to extend the length of the gate to cover the entire width of the crossing.
- ISMS will request that the AMA approve a similar resolution.

Tobacco smoking settlement funds:

- ISMS will institute action to ensure that Illinois' $9 billion share of the tobacco settlement is spent in caring for people with tobacco-related health problems, providing educational programs to stop or prevent smoking and making allocations to free clinics across the state.

Tobacco smoking ban:

- ISMS will seek statewide legislation that will prohibit tobacco smoking in enclosed and open stadia.
- ISMS will direct the AMA to push for national legislation banning smoking in those areas.
- ISMS will also support state legislation that bans hospital employees, guests, visitors and members of the medical staff from smoking within hospitals, their campuses, buildings or grounds.

PVC plastic/dioxin and medical waste:

- ISMS will ask the AMA to expeditiously complete its study of dioxin released into the environment from chlorinated hydrocarbons and promptly report its conclusions. ■

John McNulty

ISMS Delegates James Falcone, MD (left), and William Frymark, MD, review policy proposals being considered by the House of Delegates as they meet in Oak Brook to weigh decisions that will shape the Society's future direction.

ISMS online

To visit ISMS' home page, go to www.isms.org on the Internet.

- Breaking news
- Physician advocacy information
- Legislative updates (members only)
- Patient health resources
- Links to ISMS services

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Medical records blues

Chris McAllister/SIS

Is there any way to safeguard those mounting patient charts?

BY JEFF BLACK

Forever can be a long, long time, especially when surrounded by an ever-growing mountain of patient records you're not quite sure when and if you can destroy. In these days of kamikaze litigation, hanging on to patient records *ad infinitum* can significantly assist in defending any future lawsuits – although it also greatly increases the likelihood those records might get lost, stolen, damaged or destroyed.

It's another catch-22 in the medical world: damned if you do and – well, you get the picture. What's a physician to do?

According to attorney David Drake, a senior partner specializing in medical malpractice with the Springfield firm of Drake, Narup & Mead, the state of Illinois is of no great help in the matter. "There is no statute in Illinois on retention of office records over all," he said, adding that physicians must rely on the statute of limitations for specific cases to indicate how long they can be exposed to litigation. But that can prove vexing, for the state's statute of limitations varies under differing circumstances.

"For babies born with brain damage, there is no statute of limitation," Drake said. "For other children, it's eight years. In other circumstances, it runs from two to four years. Of course, Medicare and Medicaid have their own rules. So do some HMOs."

It's little wonder the general consensus seems to be to hold on to records forever and little wonder that physicians should put greater emphasis on keeping those records secure.

Leslie Fox, president of Care Communications, a Chicago-based consulting company whose specialty is helping medical facilities organize and safeguard their records, says that after the fact – after records are destroyed, damaged or misplaced – there is very little to be done. She advises physicians to clearly understand that the burden is on them. Protecting themselves from loss and, especially, liability must be among their highest priorities, she says. Security systems must be in place from the very beginning. Locks, sprinkler systems and storage areas at least four inches off the floor in case of flooding are just the basics.

"If records are damaged, lost or stolen," Fox said, "you must be able to demonstrate [to patients, attorneys, insurance companies and governmental agencies] that you had adequate security arrangements in place, that you'd taken all reasonable precautions." That includes limiting access to patient records and ensuring that employee confidentiality forms are signed. She even believes having employees bonded "might not be a bad idea."

Fox advocates computerized medical records as the optimal way to store records. "Computer records are more efficient, more secure, much safer and, if done properly, less likely to be lost," she said. "Besides, the whole idea is to get rid of paper." But, she warns, it is imperative when using a computerized system to back up files daily – preferably more often – and to keep a complete set of the most recent records securely off-site.

Harry Rhodes, a practice manager with the American Health Information Management Association, agrees with Fox. He believes that in the case of medical records, "an ounce of prevention is worth a pound of cure," and that physicians must take steps initially to preserve records, prevent losses and protect themselves in case of litigation.

He advised that when records are lost, complete and specific documentation be created to, if not explain the loss, then to chronicle it. According to Rhodes, physicians should detail when the record was last seen, in whose possession it was last seen and what steps were taken to locate it. Finally, if the record is reconstructed from other sources – hospitals, labs, billing records, etc. – that too should be noted in the documentation. Such information could prove useful in case of future litigation.

However, Rhodes was less than optimistic about the ability of any reconstruction process to assuage potential damage done when a record is lost, destroyed or stolen. "Anything you do to replace records will be substandard," he said. "Their accuracy will be questioned by third-party payers or in litigation. Reconstructed records, however complete and accurate they seem, might not even be admitted as evidence in malpractice litigation."

From his legal vantage, Drake also indicated that reconstructed materials were often "second-class documents" during litigation. "There's always a suspicion," he said, "that the physician may have 'lost' the record on purpose because it could help prove malpractice."

He agreed that immediately upon discovering a record is missing a physician should do an internal investigation and clearly document it. "You must try to prove you've made an honest attempt to show why and how you think the record was lost," he said. "But that's only if there is no patient litigation pending. If the loss is discovered in the course of litigation, let your lawyer do the work."

As if the situation weren't confusing enough – and as if there weren't reason enough to keep medical records secure at all costs – Drake reminds his physician clients of something called "spoliation," or, in the eyes of the law, the negligent loss of evidence. The case law stems from Illinois litigation in which a cleaning lady accidently threw away an X-ray needed for a malpractice suit against the physician who employed her.

"Basically," Drake said, "physicians can face two counts. Malpractice and spoliation. A plaintiff can say that the lost record, the spoliation, prevents them from proceeding with a malpractice suit. It's rare but Illinois law allows it." ■

Avoid the records-destroyed blues

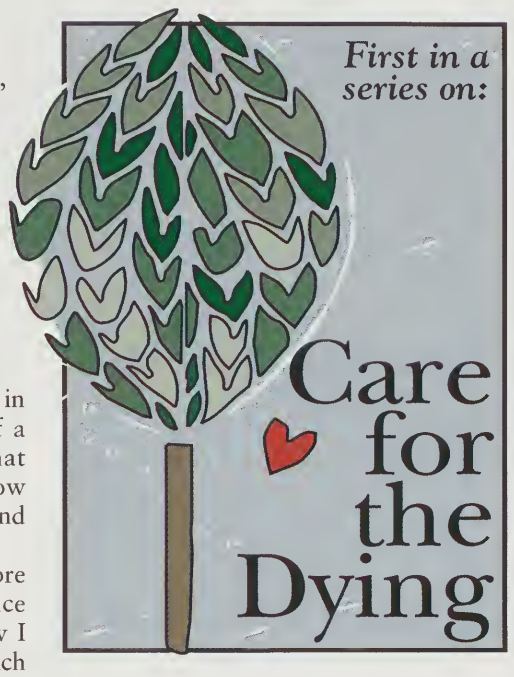
Medical-records experts suggest a few steps physicians can take to protect their records and themselves.

- **Control access to records by putting proper policies and procedures into place.**
- **Implement a record-tracking system, preferably PC-based.**
- **Back up computerized records at least once a day, if not more often.**
- **Periodically review and, if necessary, revise your security systems.**
- **Put locks in place.**
- **Keep a duplicate set of records off site.**
- **Have a working sprinkler system.**
- **Store records at least four inches off the floor in case of flooding.**
- **Consider hiring medical-records professionals to set up your system.**

A QUIET REVOLUTION

Medicine ponders challenges, changes in end-of-life care

BY JEFF BLACK



CHARLES VON GUNTEN, MD, sighed at the memory.

"Early in my career, a colleague called about 9 p.m. to ask me to check in on one of his patients overnight. The patient had head and neck cancer. He wasn't expected to live much longer. I finally went to see him around 2 a.m. The room was dark. The patient was awake, frightened, in pain. His head was the size of a pumpkin. He didn't know what was going on, and I didn't know what to do. I patted his hand and got out fast. He died at 7 a.m."

Dr. von Gunten paused before adding softly, "That experience resonates even to this day. Now I know I could have done so much more for him."

Whether or not that disturbing night provided a career road map – Dr. von Gunten today is director of Northwestern Memorial Hospital's Center for Palliative Medicine Education and Research, and medical director for the hospital's Palliative Care and Home Hospice Program – he now understands the scope of what physicians can do to make a patient's final days and hours more peaceful.

Dr. von Gunten said when he realized what such care actually could and should be, it reminded him of "the reasons I'd gone into medicine in the first place. To partner with a patient, even at the end of life."

Among a growing number of physicians, Dr. von Gunten is determined to change the way today's health care system deals with dying. From medical schools to organized medicine, there is a quiet revolution under way. But it soon may be patients who lead the charge. Many palliative care experts believe the public is ahead of the curve on this one, especially aging baby boomers who watch parents pass, then consider their own "ideal" demise.

Jane Jackman, MD, ISMS past president, said baby boomers could indeed put needed changes on a fast track. "They tend to be well-educated advocates for themselves," she explained. "They won't be pushed around. They're capable of pressing insurance companies for broader hospice benefits, lobbying legislators for pain management guidelines and demanding that doctors be up to date."

Combating the Kevorkian influence

However, Dr. Jackman added there is no need to wait for public clamor. Citing opinion polls indicating a majority could support physician-assisted suicide in certain circumstances, Dr. Jackman is adamant PAS never be a viable option. There is much physicians can do, she said, to set society in the right direction on end-of-life care – and away from PAS.

Julia Anderson-Miller

While seeds of revolution are being planted at all levels of medicine, among the most potentially far-reaching are currently being sown on campus, where medical school curriculum is embracing end-of-life skills as never before. Few places are more diligent in this effort than the Southern Illinois University School of Medicine in Springfield.

Andrew Varney, MD, assistant professor and a program director in SIU's department of internal medicine, as well as secretary of the Sangamon County Medical Society, explained his emphasis on improved end-of-life care: "We don't want more Kevorkians running around out there, writing scrips and practicing death. There is so much we can do to address people's despair."

Resident training at SIU includes ambulatory conferences, role-playing, case-based discussions and ethics consults, as well as time spent in the Springfield Memorial Medical Center's Pastoral Care Center. This is all part of the effort, said Dr. Varney, to lead residents to competencies he believes should someday be mandated for all physicians: advance directives, do-not-resuscitate orders, pain management and improved communication skills.

Creating solace at the hospital

The hospital environment provides residents with many opportunities to discuss death, dying and the issues surrounding them, Dr. Varney said. "We ask residents to question the basic goal of a therapy. It can be a real right-brain/left-brain situation sometimes. While going about the specific, goal-directed task of aggressively attempting to 'cure' a patient, we may just forget about the patient's needs. It's imperative to think about their comfort. To listen to them. Bear witness. Share their suffering. Address things 'outside' their disease, like pain assessment, relationships, unfinished business with family and friends."

By doing all that for a dying patient, he said, "the quality, comfort and connectedness they feel at the end will have been improved."

What some see as a dismaying lack of physician competency in the area of end-of-life care is a result, experts say, of not only a lack of proper training at the medical school level, but of several physician-centered issues that, in large part, must be dealt with on an individual basis.

At a recent American Medical Association-sponsored conference – Education for Physicians on End-

(See Quiet revolution, page 10)

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Quiet revolution

(Continued from page 7)

of-Life Care – these issues were a focus of discussion. AMA vice president for ethics standards and EPEC principal investigator Linda Emanuel, MD, cited a lack of communication skills as a common barrier. People attracted to the medical profession, she said – men and women able to deal with its avalanche of technical detail – may not also be blessed with "people" skills.

The ultimate adversary

Furthermore, Dr. Emanuel stated, many physicians see a patient's death as a personal failure. "We live in a death-denying culture," she explained. "We fight against death at all costs. Death is the enemy."

Dr. Varney said he knows how these physicians feel. "A physician is personally vested in [a patient's] care. If they have a bad outcome, you feel responsible. I understand that sense of moral outrage. But we have to get past some myths, such as that we can keep all patients alive forever, or that if something goes wrong, it must always be someone's fault.

"If doctors see death as the enemy," he continued, "or as a personal failure, they may well also be confronted with previously repressed emotions about their own mortality. It could be a further barrier to them. I think that's a real issue."

Another potential obstacle is that the emerging holistic approach includes attention paid to a patient's spirituality. Dr. Jackman said that "while we're not priests or vicars, if physicians are to take care of the total patient, we have to realize that to many patients the spiritual is as important as the physical. We must become more comfortable with it. We must be able to discuss these issues or at least know where to refer our patients."

Dr. Varney, too, supports acknowledging a patient's spiritual ties. "We may not be spiritual people ourselves," he said, "but we can't deny it to our patients. A lot of it is about asking what's important to them."

Eventually, Dr. Varney concluded, physicians simply must come to terms with these end-of-life issues. "If only," he said, "because of the sheer volume of patients we just can't save. We must at some point say to ourselves, 'If I'm going to be effective, I've got to get better at this.'"

Next: An Illinois community moves ahead with an effort to ensure its citizens reach the conclusion of life with comfort and dignity. ■

HIV case-reporting workshops continue

Effective July 1, physicians and other health care providers will be required to report cases of HIV infection as well as AIDS to appropriate local health jurisdictions by means of a specialized patient code number.

Training sessions on the new case-reporting efforts began in late April and are continuing through June. For more information, contact Midwest AIDS Training and Education Center at (312) 996-4429. Following are the June workshops.

June 2*, Westside Technical Institute, Chicago; June 3, U. of Illinois Levis Faculty Center, Urbana; June 8, Lake County Health Dept., Waukegan; June 9, St. Clair County Health Dept., Belleville; June 10*, Olive Harvey College, Chicago; June 10, St. John's Hospital, Springfield.

* These workshops, presented by the Chicago Department of Public Health, are intended only for Chicago health care professionals. ■

June communicable disease conference to be offered

A general session featuring a primer on bioterrorism will open the 1999 Immunization and Communicable Disease Conference, to be held June 15-16 at the Crowne Plaza Hotel in Springfield.

Designed for physicians and their staffs, infection control practitioners, public health personnel and health educators, the conference will focus on the ongoing partnerships that public health and private health care professionals must build to face the challenges of vaccine-preventable and communicable diseases.

Concurrent sessions will cover four areas: immunizations, communicable disease, tuberculosis and multidisciplinary.

Sponsored by the Illinois Department of Public Health, the Illinois Public Health Association and the Illinois Academy of Family Physicians, the conference features 30 speakers from various health departments and divisions from six states.

Registration fees are as follows: $65 (IPHA members), $95 (nonmembers), and $30 (students). Included in the fee are all sessions, conference materials, refreshment breaks, continental breakfast on June 16, lunch both days and an evening reception and dinner at the Island Bay Yacht Club on June 15.

For more information, call the IPHA at (217) 522-5687. ■

Gang behavior

'If we can't identify them, we will lose them.'

John McNulty

Mary Jensen, gang expert, speaking to the ISMS Alliance at its recent Annual Meeting.

Recognizing the signs for a safer nation

The timing did not escape Mary Jensen when she spoke about gang awareness at the ISMS Alliance Annual Meeting last month. Her presentation was just three days after the Columbine High School shooting rampage in Littleton, Colo., and Jensen, an expert on gangs, was keenly aware her audience was hungry to learn what makes kids go bad.

The teens responsible for the Colorado shootings in many ways fit the definition of a youth gang, she said. Their trademark trench coats, for example, are typical of a common identifier gangs often wear as a symbol of their affiliation, said Jensen, who teaches education classes in behavioral disorders and behavior management at the Department of Special Education at Western Illinois University.

Another fit is that "these kids were loners," Jensen said. "They were not in the mainstream of their peer groups at junior high and high school."

The topic of the presentation, actually scheduled far in advance of the Colorado incident, was selected to coincide with the Alliance's project SAVE, Stop America's Violence Everywhere, said Marybeth Syfert, Alliance immediate past president. "Violence is an important health issue and many parents and teachers do not know how to recognize gang signs," Syfert said, explaining why the Alliance chose to enlighten members on this subject.

The value in identifying gangs is that it's a first step toward prevention, said Jensen. "If we can't identify them, we will lose them." The most savable are the children that fall into the "wannabe" category. They walk, talk and dress like a gang member, but they have not yet been sucked into the illegal activities conducted by a hard-core gang member.

She encouraged parents to watch closely for signs that children may be going astray, including declining grades, gang tatoos, poor attitudes and lack of interest in family. "The No. 1 message of Littleton is to pass this information to people in your community so we can connect with these kids." Once identified, the system can intervene to teach at-risk students alternatives to gang behavior and provide them with the support they need to stay in school. ■

Town meeting educates on managed care

"Doctors on Your Side: Understanding Managed Care" was the theme of the April 27 town meeting presented by the Sangamon County Medical Society in Springfield. Approximately 90 people attended the event. Organizers said it was an opportunity for the public to gain insight into managed care from those who deal with it every day. Phillip Davis (left), of the Southern Illinois University School of Medicine, moderated; panelists (left to right) were Michael Kepple, president of Kepple Health Care Consulting; Bernice Leracz, director of insurance services for the Illinois Manufacturers' Association; and Craig Backs, MD, Sangamon County Medical Society president. Topics included the HMO appeals process, what to look for in choosing an HMO, and how to read – and live with – an HMO contract.

Ron Ackerman

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Illinois Veterans Home seeking qualified, skilled physician in geriatric medicine with training and experience. Full- or part-time. 600-bed facility. Contact Superintendent, Illinois Veterans Home – Quincy, 1707 N. 12th St., Quincy, IL 62301, or call (217) 222-8641, Ext. 202.

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Deunification

(Continued from page 1)

Delegates' Annual Meeting, where a motion to deunify fell just three votes short of the two-thirds majority required to pass. Only in Illinois, Mississippi, Delaware and Oklahoma are physicians required to belong to their county, state and national medical associations.

An ISMS survey taken last year found that 63 percent of ISMS members and 81 percent of nonmember physicians desire deunification.

More recently, the Society experienced a 22 percent drop in membership, and the majority of the physicians who canceled their membership have urged ISMS to deunify.

AMA deunification proposals have actually been considered almost annually by ISMS for the past two decades. Although survey results and the deunification vote at the Annual Meeting show about two-thirds of ISMS members currently oppose AMA unity, some physicians view it in a positive light.

"I'll always be a member of all three societies [national, state and county]," said Stephen Cullinan, MD, a Peoria internist, who has belonged to organized medicine since 1977.

It's easy to criticize an organization, he added, but the AMA is making changes in response to ISMS' pleas. "I've been disappointed in the AMA's leadership, but I don't think they were that bad in the first place. And ISMS has been doing a good job blocking bad legislation," Dr. Cullinan said.

However, opponents say the AMA is not representing their interests. "The AMA does nothing for us, but we have to pay dues to them every year," said Daniel Schnuda, MD, a Palatine pathologist. Dr. Schnuda has long preferred deunification, and he hopes that soon the issue will be back before the House of Delegates for another vote.

Physicians at Carle Clinic in Urbana – and many other group practices – also strongly favor deunification because they do not rely on the AMA to resolve issues for them, said Carle CEO Robert Parker, MD, an internal medicine specialist at the clinic.

However, they do look to ISMS for regional solutions, Dr. Parker said. Carle, which employs 300 physicians, no longer purchases a group membership in ISMS. Although its physicians can choose to join ISMS on their own, fewer than 100 physicians take advantage of that opportunity, he said, adding that Carle would be willing to provide ISMS membership to its physicians once again if deunification occurs.

"We were very disappointed when it looked like deunification would go nowhere this year. We would like to see all of our physicians enrolled in ISMS," said Dr. Parker, who has maintained his membership.

Although Sangamon County delegates lean in favor of unification, at the Annual Meeting they voted to deunify to stave off further membership losses and possibly recover some recently lost members, said delegate Craig Backs, MD.

The change of heart came after several of ISMS' top leaders reversed their positions and recommended deunification, said Dr. Backs, a Springfield internist. "We felt we needed to change our position [to match those leaders]," he said.

Nevertheless, although Sangamon County Medical Society board members acknowledge the AMA is an imperfect organization, they believe ISMS can wield the most influence on that organization by maintaining unified status, he added.

Regardless of where physicians stand on the issue, for now ISMS remains linked to the AMA. Many ISMS members may be frustrated by that fact, but it's time to move on, said Dr. Backs. "It's still our responsibility to encourage physicians to remain members anyway and to work to strengthen the Society in other ways," he said. ■

John McNulty

Democratic U.S. Sen. Richard Durbin (right) meets with Vicken Chalian, MD, (left) and Howard Chodash, MD, at the recent ISMS public affairs breakfast where he spoke on federal legislative proposals pertaining to health care.

Bargaining

(Continued from page 1)

said. Moreover, insurance companies appear to be primarily interested in the bottom line, with patient care as a secondary concern, he added.

An overriding majority of the ISMS House of Delegates voted April 25 to require the Society to form a collective bargaining unit. The challenge that lies ahead for ISMS is how to interpret current labor law, which seems to limit membership in collective bargaining units to only employed individuals. Some physicians hope that an ISMS-led unit can expand that membership to a broader range of practitioners.

"It would bother me if a collective bargaining unit applied only to employed physicians, because all physicians need to organize," said Dr. Rutenberg. Although pleased by the House of Delegates' vote in favor of a collective bargaining unit, Dr. Rutenberg noted that in the past, both ISMS and the American Medical Association failed to move quickly enough on this issue. However, the AMA's House of Delegates is scheduled to vote on a proposed collective bargaining unit at its June Annual Meeting.

Based on his own experiences, Dr. Rutenberg said he feels passionately about the need for physicians to have collective bargaining power. Recently, his two-physician practice received word from one payer that reimbursement rates would be slashed by more than 50 percent as of July 1.

In his case, Dr. Rutenberg wrote to the payer, which ultimately responded by slightly increasing the reimbursement rate. A concerted effort led by a group like ISMS could make even more of a positive difference for physicians, he added.

Rockford physicians watched the Annual Meeting's collective bargaining debate and its successful outcome with great interest. In 1997, several physicians at Rockford Clinic launched a movement to form a collective bargaining council to gain power to negotiate with their employer, the Rockford Health System.

"I think collective action is the answer; it's important for physicians to remain united and to take a strong stand," said Douglas Kaplan, MD, a Rockford ophthalmologist. Dr. Kaplan headed the fledgling Rockford Physicians' Council, which was put on hold after the RHS administration enacted most of the changes the physicians had sought. Dr. Kaplan says the larger lesson is that when doctors flex their collective muscle, they can make a difference.

Yet not all physicians greet the collective bargaining measure with enthusiasm. Robert Parker, MD, an internal medicine specialist and CEO at Urbana's Carle Clinic, questioned whether ISMS could develop a collective bargaining unit because most physicians are independent practitioners, not employees.

Even if ISMS could go ahead with its plans, Dr. Parker said he philosophically opposes collective bargaining. "I hope there is a more professional way to resolve payment and work issues," he said. Collective bargaining is too extreme a position to take and sends a terribly negative message to patients, who need to believe that their doctors will be available to them whenever necessary, he said.

Although Craig Backs, MD, agrees with Dr. Parker's concerns, he also thinks that forming a collective bargaining unit is one of the most important initiatives ISMS can undertake.

"If ISMS wants to talk about doing something for its physicians, this is clearly the way to demonstrate that it's taking action," he said. "I think the collective bargaining issue is more critical to ISMS overall than the issue of whether or not we remain unified with the AMA." ■

Sen. Fitzgerald wants Congress to expand MSAs

U.S. Sen. Peter Fitzgerald (R-Ill) has proposed a plan to expand medical savings accounts to all Americans. The MSA program was created by Congress in 1996, intent on making health insurance more affordable while giving patients the freedom to select their own physicians.

The program has succeeded in making health care more accessible, Fitzgerald said, citing estimates that 37 percent of MSA purchasers were formerly uninsured. Restrictions in the current law, however, prevent lower-income Americans and individuals who work for larger businesses from participating in the MSA program, according to Fitzgerald.

He recommends several steps Congress should take to expand MSAs, including reducing the minimum family deductible to make them more affordable, and allowing all citizens to participate, rather than only those who work for businesses with 50 or fewer employees, or self-employed individuals.

Often likened to medical IRAs, MSAs combine a catastrophic health insurance policy with a tax-preferred savings account designated for medical expenses. Individuals contribute money to their MSAs, which earn interest tax-free. Funds can be withdrawn without penalty at any time to pay medical expenses. ■

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WHEN IT MATTERS MOST

ISMS LENDS SUPPORT TO HMO LIABILITY LAWSUIT (PAGE 2)

Illinois Medicine

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PAGE 8 & 9

Keeping prescription pads away from the bad guys

PAGE 7

SPRINGFIELD SUCCESS

Mission accomplished!

ISMS leads patient rights through the Legislature

BY PAULA KRAPF

"Our patients won," ISMS President Clair Callan, MD, proclaimed at the close of the 91st General Assembly, which produced landmark managed care patient-rights legislation.

The Illinois State Medical Society (ISMS) was the catalyst behind the Managed Care Reform and Patients Rights Act, S.B. 251, having pushed for passage each year since its 1996 introduction, Dr. Callan said. "Reforming the managed care climate has been a chief priority for us, and we are ecstatic the bill has finally passed."

The decision was finalized in the closing hours of the legislative session. By a vote of 58-0 (with one abstention), state senators gave their blessing May 27 to a comprehensive managed care reform and patient rights bill that their House counterparts had resoundingly approved with a decisive 115-0 vote the night before. The victory came after weeks of intense talks led by Gov. George Ryan between ISMS, legislators, insurers, HMOs and the business community over how to refashion the reform bill so it could pass both houses.

(See MCPRA, page 6)

Photos by Ron Ackerman

The Illinois Senate floor was the scene of a string of health care successes this spring session.

Victory parade

ISMS-endorsed bills* that passed the General Assembly

BILL NUMBER	SUMMARY‡
H.B. 1780	Credentialing
H.B. 2713	Prompt pay
H.B. 2303	Hospital peer review
S.B. 13	Triplicate prescription
S.B. 953	Hospital medical staff closing
H.B. 1441	Health care professional advertising
H.B. 553	Certified registered nurse anesthetist licensing

* Gov. Ryan is expected to sign these bills into law.

ISMS-opposed bills successfully blocked from passage

BILL NUMBER	SUMMARY‡
H.B. 255	Medical practice profiles
H.B. 1624	Physicians' liability coverage
S.B. 470	Physicians' fee disclosure
S.B. 471	Physicians' billing prohibition
S.B. 823	Immunization exemptions
H.B. 913	Medical disciplinary board membership
H.B. 232/S.B. 1149	Doctor/dentist liens
S.B. 754	Medical fraud enforcement act
H.B. 1736	Clinical psychologists prescriptive authority
H.B. 1737	Birthing centers

‡ Details provided in stories at right.

ISMS Legislative victories march to Governor

In addition to patient rights, the 91st General Assembly also yielded many other successes for ISMS.

The following bills await Gov. George Ryan's signature:

Hospital peer review. A hospital, its employees and staff members involved in peer review would be liable for civil damages only in the event of willful or wanton conduct. Current law provides absolute immunity.

Triplicate prescription. The burdensome triplicate prescription form will be eliminated beginning April 1, 2000.

Physicians will use regular pads to write prescriptions for Schedule II drugs. The Department of Human Services also will monitor prescribing practices electronically.

Hospital medical staff closing. Preapplicants and those requesting an application are included among the candidates entitled to information related to medical staff membership.

Hospitals will consult with the medical staff before closing

(See Victories, page 10)

New law to end game of credentialing pursuit

Prompt-pay bill triumphs

BY PAULA KRAPF

Credentialing will no longer be a duplicative, hassle-filled process in which physicians are regularly bombarded with identical credentialing forms from multiple HMOs. In the final days of the 91st General Assembly, ISMS-backed House Bill 1780, passed the Legislature and moved to Gov. George Ryan for approval.

The bill, cosponsored by Rep. Angelo "Skip" Saviano (R-River Grove) and Sen. Bradley Burzynski (R-Sycamore), was the result of lengthy negotiations between ISMS, insurers, HMOs, hospitals and credentialing verification organizations. Once signed by Ryan, the state will develop a single credentialing form for health plans to use to credential physicians.

Rep. Thomas Dart cosponsored the prompt-pay bill with Sen. Robert Madigan.

"This is a win-win situation for the physicians, the health plans and indirectly, the patients," said Steven Malkin,

(See Credentialing, page 13)

INSIDE

ISMS lends support to HMO liability lawsuit

BY PAULA KRAPF

While many Illinois legislators eschew an HMO liability provision as part of any managed care reform legislation, the issue of whether patients can sue their HMOs is far from dead. By next fall, the state's highest court is expected to issue a ruling on what could become a landmark HMO liability case.

Petrovich vs. Share Health Plan of Illinois (now known as United HealthCare of Illinois) currently sits before the Illinois Supreme Court. The high court will determine whether physicians who provide care to an HMO's enrollees are its agents, making HMOs vicariously liable for malpractice, said ISMS General Counsel Saul Morse. ISMS recently filed a friend-of-the-court brief in support of the plaintiff, Inga Petrovich.

> *"The role of determining medical care must and should be solely with the physician and the patient."*
>
> – Saul Morse
> ISMS General Counsel

The Illinois Trial Lawyers Association also filed an amicus brief supporting Petrovich, while the Illinois Association of Health Maintenance Organizations, Illinois Hospital and HealthSystems Association and the Metropolitan Chicago Healthcare Council filed briefs backing Share.

In the lawsuit, which was filed nearly eight years ago, Petrovich's attorneys alleged that her two Share physicians negligently failed to diagnose her cancer at an earlier, more treatable stage. They also held Share vicariously liable under an apparent agent theory. In that event, an HMO could be held liable if its actions or statements led a third party, who may have been unaware of the independent contractor relationship between Share and its physicians, to believe that the physicians were controlled by the HMO.

To back up their argument, Petrovich's attorneys argued that Share's compensation arrangements with its doctors and its referral system may have constrained its physicians' medical decisions, and that Share also maintained some control over its physicians through its quality control system.

ISMS takes the view that to the extent that a health plan dictates the care provided, the organization can and should be liable for its actions if they are inappropriate or negligent, explained Morse. "The role of determining medical care must and should be solely with the physician and the patient," he said.

The managed care organization has a duty to policyholders to not make medical decisions that are most appropriately left to medical practitioners. "Managed care organizations have no legal authority, licensing or training to be making decisions affecting health care," he added.

A Cook County Circuit Court had ruled in favor of Share, stating that there was no basis in law to hold the managed care plan liable. Following an appeal, the 1st District Appellate Court unanimously overturned the lower court's ruling. In its May 22, 1998 decision, the appeals court ruled that Share could be held liable for its actions under the apparent agent theory.

Although that theory has been applied only to hospitals and hospital emergency rooms, the appeals court felt it could also apply to HMOs. Moreover, the appeals court noted that HMOs' aggressive advertising campaigns cause the public to think that they are the providers of health care. "HMOs should not be allowed to hold themselves out as total providers of health care and then seek to avoid liability based on a disclaimer buried in a contract," the appeals court ruling stated. ■

Updated medical-legal texts now available

The latest edition of The Law of Medical Practice in Illinois is now available. The updated two-volume set covers malpractice and liability law; malpractice litigation; physician licensure and discipline; the organization of practices, hospitals and managed care organization; and decision-making in reproductive care and dying.

This informative resource was co-written by Robert Kane, ISMS assistant vice president Legal Services, along with Theodore LeBlang, professor of medical jurisprudence and chairman of the Department of Medical Humanities at the Southern Illinois University School of Medicine, and Eugene Basanta, professor of law and associate dean at the SIU school of law.

The authors emphasize that while designed to assist physicians in meeting the complex and often confusing mandates of the law, the volumes are not substitutes for competent legal advice.

The Law of Medical Practice in Illinois costs $150 plus Illinois sales tax. It can be ordered by calling (800) 344-5009. ■

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PC self-test: A crystal ball to your Y2K future

After months of apocalyptic warnings of millennial-fueled doom, experts now admit things might not be as dire as previously predicted come Jan. 1, 2000.

Recent tests of computer-driven systems once believed vulnerable to the millennium's inaugural year now prove those systems less likely to malfunction.

But in the medical world, where equipment failure could very well mean death, the Y2K issue remains a question mark. The sheer scope of the equipment involved – from thermometers to pacemakers to heart-lung machines, anything with an embedded, time-sensitive computer microchip – is too vast for the industry to conduct proper premillennial checks. That equipment manufacturers have been reluctant to reveal whether or not their products are compliant has done nothing to clarify the situation.

Experts still say physicians' best option is to rely on their established vendors' relationships to get as much information as they can about what equipment is Y2K compliant. Keep asking, say the pros, until they tell you what you want to know.

Some good news is that the American Medical Association, on its Web site, is now offering physicians a simple, step-by-step test intended to determine whether their office-based PCs are Y2K compliant.

The AMA's Quick Year 2000 Test is reprinted below:

WARNING: Before performing any tests on your PC, check with your IT department [of course, most physicians in small practices do not have the luxury of an Information Technology department. – Ed.] to make sure they are in alignment with the organization's Y2K remediation strategy. Additionally, if you have software applications on your computer that take automatic action based upon the date of your PC, make sure that these applications are disabled before conducting these tests.

Otherwise, damage or loss of data may result. Also, it is always a good idea to perform a backup prior to any test of this kind.

It is estimated that nearly 80 million PCs will not properly roll over the date from December 31, 1999 to January 1, 2000. This is approximately 80 percent of the PCs in operation. The PC's age or recency of purchase is not an indication as to the year-2000 compliance. All PCs, new and old, must be tested.

The following procedures are quick methods to determine if your PC's BIOS [basic input and output system] is year-2000 compliant. The BIOS is the part of the computer that manages the system clock and reports back to software applications the current date and time when an application requests it. Two different year-2000-related problems will be tested with these procedures – the Jan. 1, 2000, problem and the Feb. 29, 2000, problem.

The BIOS on many computers will not properly recognize the rollover to the new century. Many of these computers will reset their clocks to the earliest date they were programmed to handle (Jan. 1, 1980). To test your PC for the year-2000 problem, perform the following test:

1. Set the date on your PC to Dec. 31, 1999, and the time to 23:55 hours (11:55 p.m.) and then shut down the computer in the normal manner and turn the POWER OFF. Turning the machine off is a required part of this test. Hitting the reset button is not sufficient. Many machines behave properly if they are not turned off during the century rollover.

2. Wait at least 5 minutes, and then turn on the PC.

3. Verify that the date is Saturday, Jan. 1, 2000, and the time is a few minutes past midnight.

4. If the day of the week, date or time is incorrect, you have a problem with your system BIOS. This may require a software upgrade to the BIOS or a BIOS chip replacement. Contact the manufacturer of the computer to obtain the upgrade.

5. Repeat the same test without shutting down the machine and turning off the power.

The year 2000 is also a leap year. The last time a leap year occurred at a century mark was in the year 1600. Many systems were not programmed to properly recognize the year 2000 as a leap year. To test your PC for the year 2000 leap-year problem, perform the same test as above, except in Step 1, set the date on your PC to Monday, Feb. 28, 2000, and the time to 23:55 hours (11:55 p.m.). In Step 3, verify that the date is Tuesday, Feb. 29, 2000, and the time is a few minutes past midnight. Again, if the day of the week, date or time is incorrect, you have a problem with your system BIOS.

The BIOS is not responsible for date manipulation, date math or other date-related functions that are performed by software. It is possible for the PC BIOS to handle the year 2000 properly and the application software using the date to mishandle it and cause problems. The above tests will only determine if the system BIOS is functioning properly. ■

Y2K Online

The following Internet addresses can lead physicians to more information and insight on the Y2K issue. But, experts advise, when it comes to discovering the compliance of your medical equipment, there's nothing like diligence and contacting equipment manufacturers yourself.

www.ama-assn.org – A broad, online overview of Y2K issues developed in collaboration with the American Medical Association's campaign, Moving Medicine Into the New Millennium: Meeting the Year 2000 Challenge, this Web site offers a wealth of members-only information.

www.fda.gov – Although FDA officials don't want this site to be a physician's-only Y2K source, it has much information, including a biomedical equipment database that reveals details of manufacturer compliance.

www.ha.osd.mil/hpy2K2.html – This U.S. Department of Defense Military Defense System's no-nonsense Web site provides Y2K guidance and links aimed at "awareness, assessment, renovation, validation and implementation."

www.hcfa.gov – Although the Health Care Financing Administration has been criticized for lagging behind in its own compliance efforts, this site will help you keep up with how Y2K issues might impact Medicare reimbursement.

www.Rx2000.org – All health care Y2K, all the time, this Year 2000 "information clearinghouse," a service of a Minneapolis-based not-for-profit group, offers valuable Y2K information to members and nonmembers alike.

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EDITORIAL

ISMS wins speedy remedy to slow payments

Legislators were quick to respond after ISMS explained the plight of physicians in near financial ruin waiting for third-party payers to cough up owed money. Last month the General Assembly passed an ISMS-initiated bill that holds great promise of making the reimbursement waiting game a thing of the past.

Once signed by Gov. George Ryan, the new law will require insurers and health maintenance organizations to pay within 30 days of receiving due proof of loss. Failure to make prompt payment would generate a penalty of 9 percent interest that begins on the 31st day and continues until payment is made.

It was a swift victory for Illinois physicians. The Society earlier this year targeted delayed provider payments as one of the key issues it would tackle in 1999. This publication chronicled the dilemma [The check's not in the mail: Jan. 22, 1999] created when insurers, Medicare and Medicaid consistently run late in reimbursing physicians and other health care providers. "My rent is still due," said one physician in explaining his frustration with the late-payment issue.

The Society asked physicians for help in compiling evidence to use in its campaign against delinquent payments. The stories poured in. One physician called to say that an insurance company had stopped cold-turkey on processing claims. Upon investigation, his office was told the company was undergoing an internal audit and would not be paying claims until it was over – whenever that would be.

In a separate action, ISMS also made great strides in controlling the credentialing hassles and duplication that physicians often face. A bill awaiting the governor's signature requires the Illinois Department of Public Health to develop a standardized credentials form. Physicians would fill it out once; from then on, any organization seeking particular physicians' credentials could receive copies.

ISMS extends its appreciation to the legislators who supported these bills, with particular thanks to prompt-pay sponsors: Reps. Elizabeth Coulson (R-Glenview), Thomas Dart (D-Chicago) and Andrea Moore (R-Libertyville), and Sen. Robert Madigan (R-Lincoln); and credentialing sponsors: Rep. Angelo "Skip" Saviano (R-Elmwood Park) and Sen. Bradley Burzynski (R-Sycamore).

We must also thank those members who took the time to call their legislators and personally explain how these problems affect their practice.

Additionally, gratitude is owed the many physicians who provide financial support to ISMS' legislative initiatives. This happy ending illustrates the power of the collective voice of organized medicine. Physicians are well represented in Springfield by a Society that is speaking out for their needs and getting results.

PRESIDENT'S LETTER

Communication is the atom that energizes our universe

Clair Callan, MD

Communication is at the center of everything we do. Effective communication is a key factor in how successful we are. Unfortunately messages can become garbled, so that what is heard is not the same as what was said. Remember "Telephone," the childhood game in which words were whispered in our ear, and we passed on what we had heard to the person next to us? Rarely did the last person in the listening chain hear the same words as those spoken by the first person!

In medicine, clear communication is essential. We need to communicate with our patients so they understand what their condition is and how to follow our treatment recommendations. We need to communicate with our colleagues so they understand our position on a variety of different issues.

We also need to remember to communicate with the general public. As physicians, we are an important source of sound, accurate medical information. We are the ones who should be disseminating information on how care should be managed, what the most effective treatment options are, and what patients need to know when faced with a medical treatment choice.

And we need to communicate with the business people running the different organizations on which we rely for payment. This type of communication is probably the most difficult. We are very often on the listening end of the communication chain, and we may not fully understand the language being used.

A great communication challenge for us now is to keep up with all the changes occurring in health care. This information is being disseminated at a rapid pace, which has an impact on how we practice.

"[ISMS'] new council on communication . . . will be a key factor in the Society's future success."

An easy way to keep up is to harness the power of computers and the Internet. How comfortable are you with this technology that has taken the world by storm? Has it become an essential part of your practice, or do you prefer to let someone else manage it for you? I hope you will take the time to learn how information technology can become a vital component of your practice.

The ISMS House of Delegates recently approved a new council on communication, which will be a key factor in the Society's future success. ISMS will be turning to the Internet to a greater extent to communicate with you, and we hope you will do the same. So now is the time to learn or brush up on your cyberspace skills.

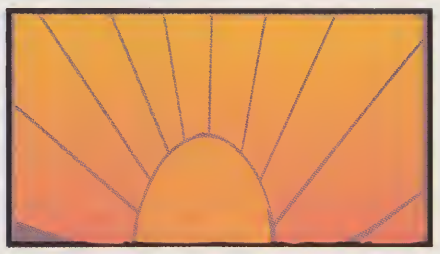
There is tremendous power in understanding the Internet. We can reach a wider audience faster than before. But to be really effective, we all have to make Internet access a part of our daily routine. So consider this another challenge from me to you: become an Internet expert and start communicating with us from cyberspace.

Speaking of challenges, how are you doing with recruiting members and adopting legislators? Now that the Legislature has completed its session, your target adoptees should be more accessible to you. Let me know how you are doing; e-mail me at callan@isms.org. And thanks again for all your efforts.

GUEST EDITORIAL

Give someone else another sunrise

By Ellen Goodman



This is not a comfortable story. But then there is no real way to find comfort for the loss of a child.

This is, however, a family story. It's about my cousin Keren Holtz, an environmentalist, a daughter, a sister and a friend who lived up to her Hebrew name: ray of light. It's about her death and legacy of life.

I am telling it now because this week is officially set aside for all of us to pay attention to organ donations and transplants. And I am telling it for her parents, my cousins Jane and Gerry, who were given a chance to wrest some small piece of meaning out of the utterly meaningless death of their 35-year-old daughter.

The family story begins with an ending. On Saturday, Feb. 1, 1997, Keren, a cyclist on Team Oregon, was out for an easy ride down a flat, open stretch of Portland highway. It was sunny and she was in the bike lane when a drunken driver came careening down the road and struck her with all his horsepower.

Less than two days after Jane and Gerry, back in Boston, received the call dreaded by every set of parents in the world, Keren was declared brain dead. They found themselves and their three sons in a strange hospital in a strange city listening to the staff from the organ bank asking – with gentleness and care – "Would you consider organ donation?"

Brain dead? Organ donor? Jane, a hospital administrator and Gerry, a retired partner from Arthur Andersen knew all the words. "I knew what brain death meant," Jane remembers with terrible clarity. "But it was as if I were hearing it for the first time. The disconnection between understanding it and accepting it is enormous."

Keren's body was still warm and breathing on life support. But this shell-shocked family had the strength to agree immediately and unanimously. After a long, long 12 hours – while patients on transplant waiting lists got the word – Keren was taken to the operating room.

There in the cool agricultural terminology of this world, her organs were harvested and transplanted in six other people.

Months later, my cousins sent a short and lovely description of Keren's life to the Northwest Transplant Bank addressed, "To the Recipients of K's Organs." In return the bank told them something about the people who carry her heart, her lungs, her liver, her kidneys. These six recipients had, collectively, nine children.

In the anonymous exchange of letters, one kidney recipient wrote simply:"I am awed at your generosity at such a difficult time." The mother of another donee wrote "Dear Friend," telling about her own daughter's terrible illness and her own gratitude.

It's been two years since the transplants. "It is strange to think someone has Keren's organs," Jane says. "But if we had said no, six people would have died."

Since Keren's death, some rules have changed. Today, hospitals are required to notify an organ procurement organization of all deaths so the families can at least be asked. There was an increase in organ donors last year – some 5,479 – but the real story is still about shortage. Some 4,000 people die every year waiting for a transplant. And 60,000 are waiting.

How many of us find it ghoulish to designate ourselves as donors or even talk about it with our families? I've learned better. "I find it hard to use words like comfort or solace," Jane says. ". . . But if you can't change reality, what good does it do to withhold the opportunity for others to live. I feel we would have been cheated if we had not been given this opportunity."

At a memorial service for Keren, Jane found words in a prayer book that had some meaning for her family – for ours: *"The sun also rises. The sun also sets. Before the sun of a righteous person sets, God causes the sun of another righteous person to rise."*

MCPRA

(Continued from page 1)

Now the bill makes its way to Ryan for his signature. Patient-rights legislation had been one of the governor's top campaign themes, and he is expected to promptly sign the bill into law.

This year had marked the fourth consecutive legislative session in which ISMS had crusaded for a patient-rights law. Sen. Thomas Walsh (R-Westchester), Rep. Jeffrey Schoenberg (D-Evanston) and Rep. Mary Flowers (D-Chicago) played important leadership roles in moving forward on this issue. S.B. 251 was sponsored by Rep. Frank Mautino (D-Spring Valley) and Sen. Walsh.

The keys to this year's success were a few delicately crafted compromises that gave legislators the incentive they needed to pass the bill. For instance, the provision that would have given patients the right to sue their HMOs was not included in the final version of the bill. ISMS and the Democratic-dominated House supported the provision, but the Republican-led Senate refused to endorse the measure. Flowers (D-Chicago), a strong proponent of the right to sue, vowed to introduce such a bill at the next session of the General Assembly. Despite her desire for HMOs to be held liable for their decisions, Flowers had said she did not want to let a patient-rights law slip away this year.

Highlights of the forthcoming law also include the following provisions:

• Ensures access to emergency services without prior authorization if the patient meets the federal "prudent layperson" definition (an average patient would feel they are in an emergency situation). Post stabilization services covered by the plan if it fails to respond to the provider's request for authorization within 60 minutes.

• Requires dissemination of information about coverage, the appeals process and the external review process in understandable language. An Office of Consumer Health Insurance will be created to provide assistance and information.

• Gives a 60-day notice of nonrenewal or termination from the plan for physicians and their patients. Patients can continue with a doctor leaving the plan for 90 days if the patient is undergoing ongoing treatment or is in the third trimester of pregnancy.

• Prohibits any restraints on doctor-patient communication, including contractual gag clauses that forbid physicians to reveal information directly related to treatment options and quality of care. Forbids retaliation against physicians who advocate for appropriate health care services for their patients.

• Provides easier access to specialists through a standing referral process for conditions that require ongoing care from a specialist or other health care provider. If comparable care is unavailable in the plan's network, an out-of-network physician will be provided at no additional cost.

• Allows patients to appeal to an external independent physician – selected by the patient, the patient's physician and the health plan – any medical-necessity decisions or any denial of a request for a standing referral to a specialist. Appeals must be expedited in cases involving urgent or ongoing services.

• Regulates utilization review programs to require timely decisions based on sound scientific evidence. Also requires that all utilization review agents follow URAC guidelines so that all reviews conducted in Illinois will be standardized.

• Creates a Consumer Advisory Committee to make recommendations to the health care plan. Consumer members will be added to the HMO Advisory Board and Guaranty Association Board so they have more input into HMO oversight. The Illinois Department of Public Health will oversee a quality assessment program to evaluate accessibility, continuity and quality of care.

• Implements complaint procedures developed by both IDPH and the Illinois Department of Insurance. The insurance department will maintain records of complaints that will be made available to the public.

• Fines up to $5,000 could be assessed to plans that violate the act.

The Managed Care Reform and Patient Rights Act includes the following pro-patient provisions:

• Care consistent with professional standards of practice to ensure quality medical and nursing practices.

• Choice of the participating physician responsible for coordinating care.

• Complete information about their condition and proposed treatment.

• Privacy and confidentiality of medical records.

• The right to purchase any health services outside the plan with their own money. ■

Coming soon: ISMIE Web site to be up and running

ISMIE Update

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Keeping prescription pads away from the bad guys

BY JAY FERRARI

Within the whirlwind that constitutes a typical physician workday, it's likely that a few non-patient-specific concerns sometimes fall through the cracks. Who hasn't misplaced their keys, forgotten to order flowers for Mom's birthday, or left a few suits sitting for yet another night at the dry cleaners?

But when it comes to concerns specific to the physician's practice – charts and tests, exams and operations – there is no room for forgetfulness. Case in point: prescription pads. Left unknowingly on an exam table or desktop, prescription pads become the means for a criminal to illicitly obtain drugs.

To minimize the insidious consequences of a stolen prescription pad – whether the standard single pad, or the more criminally coveted triplicate pad, which provides entree to the most powerful narcotics – some extra care goes a long way.

"Triplicates are the ones kept locked up out of sight," said Skokie plastic surgeon Richard Sperling, MD, in describing how his office stores its prescription pads. He advocates consistently carrying the one in use on your person.

Some addicts – regardless of whether the drugs are for personal use or street sale – are very sophisticated in their efforts to obtain narcotics, said Dr. Sperling, explaining why pads should be kept out of view. Addicts often desire only the narcotics number and not the entire pad, he said.

They know physician lingo and nomenclature, and can be very convincing in their attempts to deceive pharmacists. There have been situations where a patient simply tore sheets from a pad, rather than stealing it entirely, using the narcotics number to phone in prescriptions to nearby pharmacies, he said.

David Cromer, MD, an Evanston Ob/Gyn, agrees it is lax to leave prescription pads laying around in any medical environment, be it a hospital, clinic or physician's office. "Everyone knows of instances where people intent on facilitating self-medication helped themselves to a stray prescription pad," he said.

To reduce the chances of this occurring, in addition to keeping the pads secured, Dr. Cromer uses a generic "blank" prescription pad requiring a physician's stamp. Important information, including Drug Enforcement Administration and license numbers, must be filled in by hand. If a pad were to be stolen, thieves would find it essentially useless because it lacked the critical information needed to obtain drugs. "This," Dr. Cromer added, "definitely cuts down the illicit use." ■

TIPS FOR SCRIPTS

- Keep pads, especially triplicates, locked and out of general sight.
- Carry "in-use" pads on your person; don't think they will be unseen as desktop detritus by a keen-eyed thief.
- Consider using pads that require critical information, such as narcotics and license numbers, to be written by hand on every sheet; this minimizes the chance of someone catching a glimpse of the number, then using it later in an attempt to phone in a phony prescription.
- Report stolen pads to your local police department and the Drug Enforcement Agency, Diversion Group, (312) 353-7875.
- Consider terminating the patient-physician relationship with a patient who steals a prescription pad.
- Physicians may also find it beneficial to notify local and chain pharmacies.

MALPRACTICE ROUNDUP

Delayed MRI leads to $25 million award to paralyzed plaintiff

In Jones vs. Bashuk, an Atlanta jury made a combined award of $25 million to a Marietta, Ga., man and his wife after his permanent paralysis in the wake of a massive stroke.

As reported in the April 12 issue of The National Law Journal, the plaintiff arrived at Cobb Hospital in Marietta showing distinct signs of stroke, including slurred speech, facial drooping and difficulty standing. A neurologist ordered an MRI, but because the hours for MRIs at the hospital were limited, the technician had already left. The fact that it was Memorial Day weekend also contributed to prolonging the postponement.

The patient was transferred the following Monday to another hospital, where he obtained the MRI; however, it was treated as routine rather than urgent, and the results were never read. Early Tuesday morning, the patient suffered a severe stroke, leaving him completely paralyzed and bereft of all voluntary movement except in his left eye.

The patient's wife sued the neurologist and the two hospitals, charging that failure to adequately diagnose and treat the initial stroke symptoms led to the more drastic occurrence. Though all three defendants denied negligence, the jury awarded the plaintiff and his wife $24 million and $1 million, respectively.

Both hospitals have settled for confidential amounts; the neurologist has filed a motion for a new trial.

Tennessee court rules patient's suicide does not foreclose med mal claim

In White vs. Lawrence, decided in August 1998, the Supreme Court of Tennessee held a patient's suicide does not foreclose a claim for medical malpractice against a physician for allegedly contributing to the patient's desire to kill himself by prescribing Antabuse.

The decedent was an alcoholic who suffered from severe depression. He was being treated by the defendant-osteopathic physician for a variety of ailments, including liver and pancreas damage caused by excessive alcohol consumption. On several occasions during his treatment, the decedent told the physician he had no desire to live. The physician believed the decedent was a "likely candidate" for suicide but could not convince him to see a psychiatrist.

When the decedent's wife met with the physician to discuss the problems her husband's consumption of alcohol was having on his health, the physician responded by prescribing Antabuse, a drug that causes numerous symptoms such as headaches and vomiting when taken with even small quantities of alcohol. The physician instructed the wife to grind up the medication and surreptitiously place it in her husband's food.

Soon after the decedent's wife began secretly administering the Antabuse, the decedent began complaining of headaches, hot and cold flashes, and pain. He was taken to a local hospital; however, because he did not realize he had been given Antabuse, he was unable to advise the emergency room personnel, who diagnosed him as suffering from heat exhaustion. Four hours after his dismissal from the emergency room, the decedent shot himself in the head with a pistol.

The wife filed suit against the physician, claiming his negligent prescription of Antabuse led to her husband's suicide. The physician filed a motion for summary judgment, asserting the decedent's act of suicide was a superseding, intervening cause of death that barred recovery as a matter of law.

On appeal, the state supreme court upheld the trial court's denial of the motion for summary judgment. It found that an intervening act that is a "normal response" to the defendant's negligence would not relieve the wrongdoer of liability so long as the act was reasonably foreseeable and the defendant's negligent conduct was a substantial factor in causing the injury. Furthermore, the fact that the decedent was neither insane nor bereft of reason at the time does not necessarily mean the suicide was unforeseeable.

ISMS-supported bill eliminates burdensome triplicate prescription forms

BY PAULA KRAPF

Mary Bretscher, MD, cares for terminally ill patients daily, and she tries to ease their suffering with good pain management practices. But a state law that governs the prescription of controlled substances – narcotics such as morphine and codeine are a major component of care in such cases – has often been an impediment to quality care.

"Having to use a special prescription form to prescribe controlled substances for patients who need them inserts a bureaucratic hurdle when you're trying to provide good pain control," said Dr. Bretscher, a Springfield oncologist who is also the assistant director of Hospice Care of Illinois.

Keeping up with the paperwork is another headache. Hospice nurses constantly have to track down doctors to get the prescriptions from the physicians, Dr. Bretscher said.

In addition, many physicians in Illinois choose not to participate in the triplicate program due to its complexity. That means the nonparticipating physicians cannot prescribe narcotics to their patients who need them, she noted.

However, those troublesome triplicate prescription forms will soon be out of print in Illinois thanks to an ISMS-supported bill that recently passed the Legislature. Pending Gov. George Ryan's signature, the new Controlled Substances Prescribing Act will be on the books in Illinois, slated to take effect April 1, 2000.

Following the lead of 17 other states, the Illinois legislation requires prescribing physicians to fill out a regular prescription single-paper form that their patients would give to the dispensing pharmacist.

The pharmacist, in turn, would electronically transmit the data to the Illinois Department of Human Services to compile and distribute.

Senate Bill 13, sponsored by Sen. Dave Syverson (R-Rockford) includes the following provisions:

- Eliminates the official triplicate prescription forms in favor of an electronic system.
- Creates a controlled substance prescription monitoring program for Schedule II drugs.
- Develops a central repository to collect information about dispensing controlled substances.
- Maintains confidentiality of information in the central repository.
- Establishes an advisory committee to help the DHS implement the controlled substance monitoring program.

The current triplicate prescription forms were introduced in the mid-1980s to enhance Illinois' 38-year-old prescription monitoring program, said Sue Gorman, a regulatory supervisor for the triplicate prescription program at DHS. That program was developed to prevent substance abuse by physicians or patients. The agency reports it receives between 15,000 and 20,000 prescription forms each month from pharmacists who fill the prescriptions.

The numerically sequenced triplicate forms became a nuisance for doctors by generating a flurry of paperwork. In addition, the regulation prohibiting refills without a new prescription poses a problem for patients with chronic pain who may need greater amounts of Schedule II controlled substances. Physicians, in turn, fear that writing too many prescriptions could trigger an investigation.

Many physicians felt the triplicate forms were a barrier to patient care because they perceived that "Big Brother," or the government, was scrutinizing their prescribing habits, added Randolph Malan, manager, bureau of pharmacy and clinical support services for DHS' Division of Disability and Behavioral Health. The division oversees Illinois' triplicate prescription program.

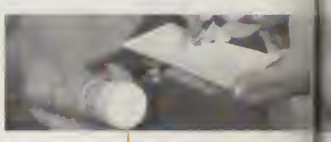
Because physicians find the triplicate prescription program burdensome, participation has been low: roughly 60 percent of Illinois' 35,000 physicians use triplicate prescription forms. "That means patients of physicians not participating may be underserved with regard to appropriate, modern pain management," Malan noted.

Dr. Bretscher believes S.B.13 has its shortcomings, but it represents a significant step in the right direction. "It's a symbolic measure; the state realizes that there have been problems with current pain control procedures so it will eliminate some of the legislative and regulatory barriers," she said. The bill does not go as far as she would like; for instance, physicians still cannot phone in Schedule II prescriptions except during an emergency, and patients still have to take a written prescription form from their physician to the pharmacy.

Yet, doctors will be able to use their regular prescription forms for controlled substances, and Dr. Bretscher believes that some doctors would start prescribing narcotics if they didn't need triplicate forms. "That would help with pain management in general," she said.

ISMS has expressed concern that using regular prescription forms for prescribing controlled substances could make it easier for drug addicts to get their hands on prescription pads. Physicians will need to guard regular prescription pads with the same caution used for the triplicate pads. Overall, however, the Society understands the value to patients of simplifying pain control prescriptions.

"Eliminating triplicate forms is a subject whose time has come, and it will ensure we can provide good clinical care to the population of this state," Malan said. ■



The Drug Enfo for prescribing

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EEN NEED AND ABUSE

SMS spells relief E-D-U-C-A-T-I-O-N

When a worried doctor sought advice from addiction-medicine specialist Martin Doot, MD, he told Dr. Doot that the Illinois Department of Professional Regulation had questioned the number of controlled substance prescriptions he wrote for a patient who suffered from chronic pain.

The situation highlighted how physicians can inadvertently get into trouble for their lack of knowledge about prescribing controlled substances. Dr. Doot has led CME courses on how to distinguish between patients seeking to feed an addiction and those who legitimately need medication for chronic pain.

The line can get blurred because many prescription pain killers, including Schedule II narcotics such as morphine and codeine, have a high potential for abuse or addiction. Some physicians, especially those less experienced in pain management, fear regulatory agencies looking at their prescribing practices, explained Dr. Doot, an active participant in ISMS Councils and Committees.

In order to remedy the educational deficit in this area, ISMS has formed a working group of physicians and state regulatory agencies to establish controlled substance prescription- education programs for physicians, medical students and residents. The Society has teamed up with IDPR, the Drug Enforcement Administration and the Illinois Department of Human Services on the project.

One problem to overcome is that fear of government scrutiny sometimes leads physicians treating patients with legitimate chronic pain to underprescribe, according to Dr. Doot. IDPR is aware of physicians' fears.

> *"Doctors who prescribe or dispense controlled substances appropriately don't need to worry."*
>
> – Andrew Gorchynsky, MD
> Illinois Department of Professional Regulation

"If we don't monitor controlled-substances prescribing, unscrupulous prescribers will have a field day," said Andrew Gorchynsky, MD, IDPR's chief medical coordinator. "But we also want to make sure physicians aren't afraid to use controlled substances."

Dr. Gorchynsky, along with IDPR's deputy medical coordinator, reviews complaints – and investigations of complaints – against physicians, and recommends the action for IDPR's medical disciplinary board.

IDPR is alerted to potential prescribing abuses in several ways: when the amount of controlled substances a physician prescribes suddenly takes a large jump, the Drug Enforcement Agency brings a potential problem with a physician to IDPR's attention, or someone complains to IDPR about a physician. In those cases, IDPR requests an explanation from the physician.

Doctors who prescribe controlled substances appropriately don't need to worry, as long as they follow the law and maintain adequate records, Dr. Gorchynsky said. The lack of regular monitoring and good documentation are where problems arise, he said. There have been cases in which a doctor wrote a controlled substance prescription for a patient he or she hadn't seen in years. "Those physicians were disciplined," he noted.

Physicians should make appropriate consultations when treating patients with chronic or acute pain. Refer such patients to a pain clinic, and follow the clinic's protocols to ensure the patient receives quality care without becoming addicted to the medication, he said.

Another controlled-substance issue centers on physicians self-prescribing. Easy access can sometimes be a prescription for addiction, Dr. Doot said.

Moreover, the technical aspects of writing a prescription present opportunity for errors, according to Dr. Doot. Physicians receive little education in medical school or during residency on how to write and document their prescribing practices, he noted. Lack of training makes the state's current triplicate prescription system, used only for Schedule II drugs, confusing. (However, a new controlled substances prescribing law will take effect next year, making the triplicate forms obsolete. Physicians will instead use their regular prescription pads for prescribing all medications, including Schedule II drugs.)

The goals of the educational programs being developed are to train medical students and residents on proper prescribing habits, and to educate physicians identified as problem prescribers as well as those who self-prescribe. ■

Prescribing tips

Administration offers the following advice
d substances responsibly:

mber of prescription pads in use
a safe place where they can't be stolen.
orders for Schedule II drugs in ink or
r use a typewriter. Do not forget to sign
d signatures are prohibited.
cribed should be written out in words as
onding Arabic or Roman numeral to
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escriptions for large quantities of
nces unless absolutely necessary.
inimum stock of controlled substances
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a patient mentions that another
n prescribing a controlled substance for
lt the other physician or the hospital
mine the patient thoroughly and decide
stance should be prescribed.
m should be used only for writing a
r – not for notes or memos – because a
l erase the message and use the form to

iption forms in advance.
ate record of controlled substances

cist when he or she calls to verify
t an order; they share corresponding
dispensing any prescription.

ISMS to consider model guidelines for use of controlled substances

To protect legitimate uses of controlled substances yet prevent drug diversion and eliminate inappropriate prescribing practices, in May 1998 the Federation of State Medical Boards of the United States adopted model guidelines for using controlled substances in treating pain. ISMS will use that policy as a springboard for developing its own pain-management regulations.

The Federation's model includes the following suggestions for evaluating the use of controlled substances for pain control:

- Begin with a thorough evaluation of the patient, which includes a complete medical history and physical examination that is well documented in the medical report.
- The medical report must also document the nature and the intensity of the pain, current and past treatments, underlying or coexisting diseases or conditions, the effect of the pain on the patient's physical and psychological function, and his or her history of substance abuse.
- A written plan should disclose how treatment success will be determined and indicate if additional diagnostic evaluations or other treatments are planned.
- The physician must discuss the risks and benefits of the use of controlled substances with the patient, who should receive prescriptions only from one physician and one pharmacy when possible.
- If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should use a written agreement to outline the patient's responsibilities. The agreement can include taking urine/serum medical levels screening when requested; recording the number and frequency of all prescription refills; and providing reasons for discontinuing drug therapy, including agreement violations.
- Periodic reviews of the course of treatment and the physician's evaluation of progress toward the treatment objectives will determine whether to continue or modify therapy.
- Physicians should be willing to refer patients as necessary for additional evaluation and treatment.
- Accurate records are essential and should include: the medical history and physical examination; diagnostic, therapeutic and laboratory results; evaluations and consultations; treatment objectives, discussion of risks and benefits; treatments; medications (include date, type, dosage and quantity prescribed); instructions and agreements; and periodic reviews. ■

Victories

(Continued from page 1)

membership in either the entire or any portion of the medical staff department.

Health care professional advertising. All licensed health care practitioners must include the appropriate titles such as MD, DO, OD and DC in all advertising and promotional materials.

Certified registered nurse anesthetist licensing. CRNAs would be licensed similar to the advanced practice nurses law and in conformance with ISMS policy. The advanced practice nurses law was passed last year.

ISMS tenacity prevented the following bills from advancing:

Medical practice profiles. The public would have had access to individual profiles on persons licensed under the act, including criminal charges, disciplinary actions, hospital privilege revocations and medical malpractice awards. ISMS noted most of this information is already made available to the public.

Physicians' liability coverage. All physicians would have been required to maintain an onerous minimum of $1 million in liability coverage.

Physicians' fee disclosure. Doctors would have faced the administrative burden of being required to disclose the amount of the charges before requesting authorization by the patient for a treatment plan. The disclosure would have to be at least equal to 90 percent of the final charges.

Physicians' billing prohibition. Doctors would have been limited to billing enrollees or insureds only for copayments, deductibles and fees for services not covered instead of for the balance of services that HMOs don't cover. Physicians would not have been able to charge patients for services the HMO did not cover.

Immunization exemptions. Parents would have had the ability to conscientiously object to their children receiving state-mandated immunizations, but ISMS and other medical groups noted that this could lead to infectious-disease outbreaks.

Medical disciplinary board membership. The two members representing the public would have been granted voting privileges, but ISMS contended that only physicians' peers should make final disciplinary recommendations to the director of the Illinois Department of Professional Regulation.

Doctor/dentist liens. Liens would have been limited to one-third of an award, which would have greatly reduced physicians' chances of receiving payment.

Medical fraud enforcement act. Fines imposed for medical fraud would have been deposited into a special Medical Fraud Enforcement fund, which ISMS opposed because billing errors were included in the definition of medical fraud.

Clinical psychologists' prescriptive authority. Certified clinical psychologists would have been allowed to prescribe and dispense drugs and medicine, but ISMS did not feel they had sufficient training or experience to have this authority.

Birthing centers. The state would have established requirements for location, services and standards for no more than 10 birth-center alternative models in the state. ISMS opposed the bill because the centers did not meet American College of Obstetricians and Gynecologists' standards. ■

ISMS helps AMA distribute $70,000 to state medical schools

As part of its ongoing philanthropic initiative, the American Medical Association Foundation recently announced the distribution of more than $70,000 to Illinois medical schools. ISMS worked in partnership with the AMA Foundation, the philanthropic arm of the AMA, to distribute the funds, intended to help offset the expense of medical education while simultaneously supporting areas of medical research.

The gifts, made up of generous contributions from physicians and their families, also provide special funds for medical students to use in a variety of programs.

The AMA Foundation is dedicated to ensuring that the medical education system in America remains the world's best, said J. Edward Hill, MD, foundation president. Awards are given in two categories: Medical School Excellence and Medical Student Assistance.

Illinois schools benefitting from this program include: Rush Medical College, University of Chicago, Northwestern University, University of Illinois College of Medicine, University of Health Science/Chicago Medical School, Loyola University, Southern Illinois School of Medicine, Chicago College of Osteopathy, and the University of Illinois Foundation for the colleges of medicine in Urbana-Champaign, Rockford and Peoria. ■

Classified Advertising

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Illinois Medicine is published every three weeks except biweekly in May and June; ad deadlines are four weeks prior to the issue requested. Although ISMS believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify ads at its discretion. Ads will be edited to conform to Illinois Medicine style.

Positions and practice

Physicians needed full time or part time. All surgical or medical specialties. Suburban Chicago locations: northwest and western suburbs. Various specialties: general surgery, urology, family practice, gastroenterology, Ob/Gyn, internal medicine, gynecology, gastrointestinal, orthopedics, ophthalmology, dermatology, ENT, plastic surgery, pediatrics, family practice with pediatrics, anesthesiology, cardiology and other specialties. Malpractice insurance available. Hourly or salaried positions available. Positions start January, April, July and October. Mail CV to: Administrator, 203 E. Irving Park Rd., Wood Dale, IL 60191, or fax CV to (630) 595-9097.

Primary care – Permanent and temporary positions. Placement assistance to individual physicians or practices seeking additional staff. Call Southerby Consultants, Ltd. at (708) 687-1919 or fax to (708) 687-2867. Visa assistance unavailable.

BC/BE cardiologist is sought to join a three-physician cardiology group in Racine, Wis. Contact Suzanne Purath (414) 631-8780 or fax CV to (414) 631-8784.

Home Physicians, an innovative medical group located in Chicago/northwest Indiana and specializing in house calls, is seeking physicians to join its practice. We are looking for individuals with training in primary care/surgical debridement. Full- and part-time positions available. Please fax CV to Scott Schneider at (773) 384-7053 or mail to Home Physicians, 1735 N. Ashland Ave., Chicago, IL 60622. Call (773) 292-4800.

Excellent opportunity available for a BC/BE anesthesiologist – A prestigious practice in central Illinois comprising 43 physicians and 19 nurse anesthetists is seeking a BC/BE anesthesiologist. The practice is very well established, covers all types of anesthesia and enjoys a congenial relationship and the respect of the surgeons. Excellent benefits, one year full salary and two-year partnership tract is offered. Submit CV to Associated Anesthesiologists, S.C., Recruitment Committee, 5401 N. Knoxville Ave., Suite 49, Peoria, IL 61614.

Ob/Gyn MD needed for pelvic examinations. Two days per week in northwest Chicago suburb. Fax resume to (847) 296-5516.

Family practice – Appleton, Wis. – 180-physician multispecialty group seeking BC/BE family physician in the beautiful Fox Valley. 1 in 7 call schedule, outstanding colleagues, facilities and compensation/benefits. Call (800) 611-2777, fax to (414) 784-0727, or e-mail: cmatenaer@earthlink.net.

Emergency physician needed in southern Illinois. Good remuneration. Board and lodging, malpractice insurance covered. Yearly census 8,000. Few trauma cases; majority diverted to 300-bed hospital across the Ohio River. 12- or 24-hour shifts available. Reply with CV and references to: Enrique Yap, MD, Director, Emergency Service, 510 W. 10th St., Metropolis, IL 62960. Call (618) 524-2148 or fax to (618) 524-4998.

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Chicago, suburbs and nationwide – Excellent, unadvertised opportunities for physicians in all specialties with multispecialty groups, hospital affiliations and private practices. Many practices tailored to meet your needs. Attractive salary and compensation packages. Contact: Debbie Aber, Physician Services, 1146 Parker Ln., Buffalo Grove, IL 60089. Call (847) 541-9347 or fax to (847) 541-9336.

Physician needed – family physician. Full-time on salary or partnership. Practice has been located in Chicago area for many years. Please call Arvin Shah, MD, at (773) 772-4319, or write to 2957 W. Armitage Ave., Chicago, IL 60647.

Situations wanted

Board-certified internist seeks full-time or part-time opportunity or practice to buy in Chicago area. Call (630) 261-0992.

Board-certified nephrologist looking for full-time or part-time practice opportunity in Chicago area. Call (630) 261-0998.

Physician for more than 15 years practicing in Chicagoland area (family practice, mostly adult medicine) looking for partnership in Illinois or salaried position within 100-mile radius of Chicagoland. Call (708) 301-2920.

For sale, lease or rent

Medical equipment for sale – Pulse oximeters: $395/new; spirometry units: $1,395/new; Doppler units: $495/new; Interp EKGs: $2,895/new. Call MESA, Inc. at (847) 759-9395.

Medical center available for rent – Wise Road in Schaumburg. Excellent location. Office can accommodate one to three physicians. Call Cee Bee Management Co. at (847) 438-5703 or (773) 261-3771.

Medical/dental offices for rent – Must see. Newly decorated offices include waiting room, 3 exam rooms with modular cabinets and sinks in each room, private office, business area and laboratory. Conveniently located on Austin Avenue, just south of Belmont Avenue in Chicago. For information call (773) 889-3520.

Refurbished medical equipment for sale – From exam rooms to operating rooms. Autoclaves, EKGs, PT monitors, anesthesia machines, defibrillators, exam tables, power tables, OR tables and lights. Warranties. Call Medical Equipment Sales Associates at (888) USED-EKG (873-3354).

Naperville Medical Center – New 40,000-square-foot medical office complex in growing downtown Naperville, one block from hospital, offers office space for ENT, oncology, ophthalmology, dermatology, orthopedic and primary care. For more information, call (630) 527-6500 or page (630) 342-8998.

Medical suites from 607 to 1,040 square feet available in prestigious Mount Prospect medical building. High-traffic location near Northwest Community and Holy Family hospitals. Call (847) 465-2297.

Miscellaneous

Exam chair, table reupholstery – All makes and models. One-day service around your time off. Stools and waiting room furniture. Hundreds of colors in the most durable, cleanable, stain-resistant vinyls. Miller Professional Upholstery, (630) 761-1450.

Vacation in our Jamaican villa – Great family place or deductible as business retreat! Cook, maid, pool, beach. Sleeps 8. 11/16-4/15: $2,495/week 1-4 people; $3,295/week 5-8 people. Low season: $1,895/$2,295. See photos, layout at Web site www.cpacomputerreport.com/ybird/. Phone (608) 231-1003 or (800) 260-1120 for brochure.

Transcription service – Digital and tape – 9.5 cents per line (based on volume), phone-in dictation, modem, messenger service, 24-hour service. Excellent references. Lee-Perfect Transcribing, (312) 664-1877.

Credentialing

(Continued from page 1)

MD, who is an internal medicine specialist for Medical Care Group in Skokie. A longtime advocate for resolving the glitches in the current credentialing process, Dr. Malkin had described some of its horrors in "Credentialing Pursuit," [Illinois Medicine, Feb. 12, 1999].

Glen Ellyn thoracic surgeon Raymond Dieter, MD, agreed that the current credentialing environment is bogged down with needless red tape. In fact, Dr. Dieter introduced a successful resolution to the April ISMS House of Delegates Annual Meeting supporting the development of a single credentialing form. He welcomes the upcoming state law.

"Most physicians now are in six, eight or even 10 HMOs, and they're repeatedly filling out credentialing forms for each one," Dr. Dieter said. The real question credentialing should address is whether or not a physician is qualified to treat patients, he added.

Key provisions of the forthcoming credentialing law include:

• Standardized forms for credentialing and recredentialing must be used by all health care plans, including HMOs, beginning July 1, 2000. The Department of Public Health, with the assistance of an advisory council that includes physician representatives, will develop the forms. The forms will contain credentialing data commonly collected by plans.

• Health plans must collect credentials' data from physicians only once, beginning Jan. 1, 2001. The physician will fill out the standardized form one time and send copies to all of his or her plans.

• Plans cannot recredential physicians more often than once every two years unless it is required as a result of quality assurance concerns.

• All health care plans must use a uniform site survey instrument. Each site visit, if required, will collect the same information, so physicians will know what to expect from the site survey process.

• Health plans will conduct only one site visit to a physician's office, beginning July 1, 2001. The single inspection will cover all of the physicians' plans and occur once every two years.

• Credentialing decisions must be made 60 days following the health plan's receipt of the physician's complete credential information. Verification of the information must also be made in a timely fashion.

"This bill should make physicians happy and save them a lot of time and bother," said Dr. Malkin. New physicians, in particular, should obtain some much-needed relief from the bill because they currently spend a year or more waiting to be credentialed, and during that time they can't treat patients, he added.

Prompt-pay bill awaits Governor's approval:

In another significant ISMS legislative triumph, H.B. 2713, the prompt-payment bill, is expected to soon be signed into law. The bill will greatly reduce physicians' woes regarding timely compensation from insurers and health plans. Major provisions of the bill, which was cosponsored by Rep. Thomas Dart (D-Chicago) and Sen. Robert Madigan (R-Lincoln), include the following:

• Once a physician or other health care practitioner files a due proof of loss, insurers and Health Maintenance Organizations have 30 days to pay the claim.

• Failure to make prompt payments generates a penalty of 9 percent interest that begins on the 31st day and continues until payment is made. The payments will be automatic, and the physician will not have to bill the insurance company or HMO to collect that money.

• Independent Practitioner Associations and Physician Hospital Organizations have 60 days to pay claims until 2001, then IPAs and PHOs must meet the 30-day payment requirement.

• If a claim is not clean, the insurer, HMO, IPA or PHO has 30 days to notify the physician or health care practitioner of the error. The organization also must explain how the doctor or practitioner should rectify the mistake.

• For capitation payments, the payer has 60 calendar days to notify the physician or other practitioner that a patient has selected him or her. The payer also must let the practitioner know the date that the selection takes effect. The initial capitation payment must occur within 60 days of the effective date, and subsequent payments must be made monthly. ■

IHCA's June seminars deal with dementia

The Illinois Health Care Association is offering a series of seminars in June that will discuss state-of-the-art dementia care, key elements of dementia special care and the Joint Commission dementia special care protocol.

Dates and locations are:

• June 15 - Mount Vernon (Holiday Inn)
• June 17 - Springfield (Hilton)
• June 30 - Naperville (Lisle/Naperville Hilton)

The IHCA is the largest long-term care association in Illinois, representing 500 long-term care providers and the residences they serve.

Members include a variety of nursing facilities and residences.

For more information on the seminar, contact Amy Killam in the IHCA office at (800) 252-8988. ■

IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

January 1999

Solomon Greer, Chicago – physician and surgeon license placed on indefinite probation due to an outstanding income tax liability owed the Illinois Department of Revenue.

Ignas Gediminas Labanuskas, Hinsdale – physician and surgeon license reprimanded, probation extended to April 2000 and fined $1,000 for allegedly failing to take a complete patient history and overcharging for the services rendered.

Reginald L. Vernier, Chicago – physician and surgeon and controlled substance licenses placed on probation for two years for allowing his wife to manage the controlled substance purchasing and dispensing at his office with no controls, possibly allowing her to divert large quantities of controlled substances, failing to ensure proper controlled substances record keeping requirements were followed and for prescribing large quantities of controlled substances for some patients.

February 1999

Norberto T. Agustin, Oak Park – physician and surgeon license indefinitely suspended after violating the terms and conditions of a previously ordered probation.

Ruth Morgan Cademartori, Lombard – ordered to cease and desist the unlicensed practice as a physician and surgeon.

Luis D'Avis, Skokie – physician and surgeon license revoked for allegedly touching and fondling four female nursing home residents in an inappropriate manner.

Luisito A. Evangelista, Chicago and Las Vegas – physician and controlled substance licenses temporarily suspended pending proceedings before the Illinois Medical Disciplinary Board for purchasing narcotic prescription drugs which he would take to Nevada and sell.

Cassim Igram, Buffalo Grove – physician and surgeon license reprimanded and fined $4,000 for allegedly failing to provide requested information to the Department in a timely manner. Dr. Igram voluntarily elected to have his medical license permanently placed on inactive status.

Pandaranga Rao Lingam (also known as Rao Panduranga Lingam), Columbus, OH – physician and surgeon license placed on indefinite probation after being disciplined in Ohio for controlled substance violations.

Timothy H. Massey, Kirkland, WA – physician and surgeon license reprimanded for failing to respond to a Department request for information in a timely manner.

Anna Mianowska, Chicago – physician and surgeon license reprimanded and fined $500 for putting medication into sample bottles for a patient.

Roberto Padron, Chicago – ordered to cease and desist using the abbreviation "Dr." with his name without noting he does not hold an Illinois license.

Raymond Reich, Chicago – physician and surgeon license reprimanded after being disciplined in Massachusetts for falsifying to an insurance carrier he was board certified in internal medicine.

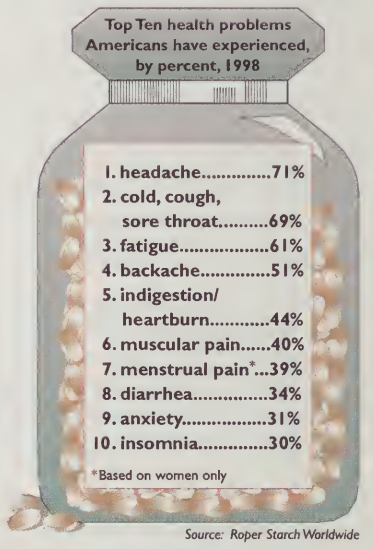
March 1999

Felix Vasquez-Ruiz, Chicago – physician and surgeon license reprimanded and fined $2,500 for aiding and abetting the unlicensed practice of medicine by Roberto Padron.

Luis O. Bacayo, Ransom – probation of physician and controlled substance licenses extended until Nov. 13, 2001, for failing to comply with a previously ordered probation.

Prasert Luangkesorn, Morton Grove – physician and surgeon license indefinitely suspended for engaging in immoral conduct by committing an act of sexual misconduct with a patient.

Ramesh Babu Vemuri, Crystal Lake – physician and surgeon license indefinitely suspended for allegedly engaging in an inappropriate relationship with a patient.



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WHEN IT MATTERS MOST

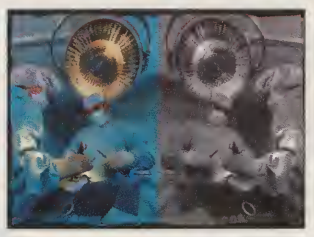
ER YEAR FOR HEALTH CARE PAGE 3

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JUNE 18 1999

Death certificates: Make no mistake

PAGE 2



Wrong-site surgery

PAGE 5

Reform law's here; what does it mean?

Jay Barnard

Sen. Thomas Walsh testifies before the Senate Insurance and Pensions Committee in favor of the patient rights bill he cosponsored with Rep. Frank Mautino. The bill passed the General Assembly last month.

Physicians, patients stand to gain

BY PAULA KRAPF

Illinois' first Managed Care Reform and Patient Rights Act is being hailed by physicians and consumers as a long-overdue shield of protection against HMO and health care insurance abuses.

"This legislation puts the patient first, as opposed to placing business first," said ISMS President Clair Callan, MD. The Society worked persistently over the past four years to pass this comprehensive patient rights bill. The act, which finally passed the General Assembly last month, is designed to simplify the cumbersome tangle that patients often encounter when attempting to obtain access to health care, she said.

One of the cornerstones of the legislation is the stipulation that emergency services will not require prior authorization if the patient meets the federal "prudent layperson" definition – that is, if an average patient in similar circumstances would believe he or she is in an emergency situation.

Many HMOs have required their enrollees to obtain preapproval for emergency care, which can delay treatment, said Susan Nedza, MD, an emergency physician at Elmhurst Hospital. "In many cases, delayed care consumes more resources and costs significantly more than emergency treatment," she said.

Dr. Nedza is immediate past

(See Reform, page 6)

Cost increases minimal

Despite critics' claims that the state's Managed Care Reform and Patient Rights Act will cause HMO premiums to experience double-digit increases, the fiscal impact will amount to only pennies per day, said ISMS President Clair Callan, MD.

Furthermore, the benefits gained by giving patients unrestricted access to the care they need far outweigh the projected cost, Dr. Callan said.

(See Cost, page 8)

Not just any number

ISMS seeks to stem unfit release of DEA numbers

BY PAULA KRAPF

Although a physician's Drug Enforcement Agency number should be closely guarded and released only when a physician prescribes a Schedule II controlled substance, doctors' tight control over their numbers in recent years is being compromised.

Drug companies, insurers and other health care entities are increasingly pressuring physicians to supply those numbers for identification. Furthermore, several pharmacists are demanding physicians' DEA numbers for all prescriptions, not just for controlled substances.

But now ISMS, with the help of the American Medical Association, will seek legislative and other means to halt the inappropriate dissemination of DEA numbers.

"Every time we turn around, some pharmacist wants our DEA number," said Chester Danehower, MD, a Peoria dermatologist. Dr. Danehower said he writes very few Schedule II prescriptions, yet some pharmacists have said they will not fill his non-Schedule II prescriptions without his DEA number. In those cases, Dr. Danehower has reluctantly given in to their request.

More alarming is the way in which insurers and others are using the DEA number as the primary physician I.D. number.

"The DEA number is not supposed to be disseminated for anything other than Schedule II prescriptions. There are other numbers available for physician identification," said Dr. Danehower. Alternatives include a physician's Social Security number, medical education number or state medical license number.

Believing it was time for physicians to take a stand on the matter, Dr. Danehower prepared a resolution introduced by the Peoria Medical Society and approved by ISMS' House of Delegates at its Annual Meeting in April. That resolution was combined with one from

(See DEA, page 10)

What physicians should know before providing professional courtesy

BY PAULA KRAPF

Peoria dermatologist Chester Danehower, MD, is a firm believer in extending professional courtesy to medical colleagues and their families. He's been both the recipient and the provider of such care, and he thinks it's an exemplary service that physicians can provide.

Yet many physicians are leery of providing medical care to other physicians or their families free of charge, at a discounted rate or to bill for insurance only. Some think professional courtesy is illegal, while others, confused by government regulations, are afraid they will be prosecuted for fraud.

Dr. Danehower said many colleagues practicing in his area say they "have no idea what they can do." With the backing of the Peoria Medical Society delegates, Dr. Danehower introduced a resolution to the ISMS House of Delegates at its 1999 Annual Meeting that will educate physicians about the American Medical Association's and the Health Care Financing Administration's policies on professional courtesy. The resolution asks the AMA to mail a flyer to physicians nationwide that

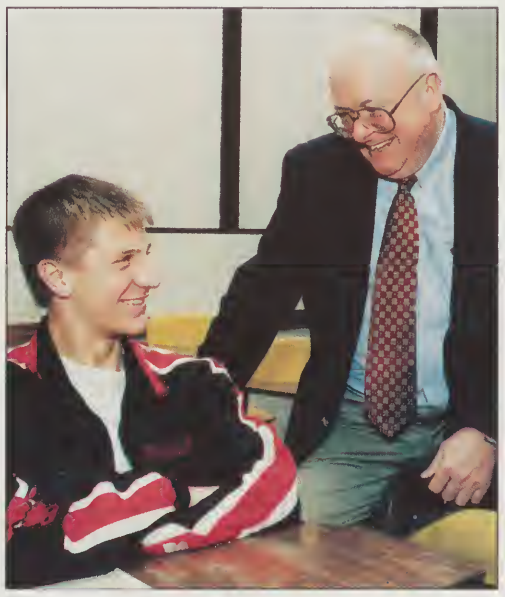
(See Courtesy, page 8)

John McNulty

Chester Danehower, MD

INSIDE

Physicians inspire future doctors at high school career night



John McNulty

Orthopedic surgeon and sports medicine specialist Bates Noble, MD (top photo) shares a laugh with high school student Daniel Gajos while pediatrician Jerome Meservey, MD (bottom photo) answers questions from a group of students at the Northwest Suburban High School District 214's first Medical Careers Night. Held recently at Rolling Meadows High School, the event featured an overview session for students and parents, followed by breakout sessions on specific medical careers.

In addition to Dr. Meservey and Dr. Noble, session speakers included general surgeon Alfred Clementi, MD; pharmacist Edward Novak; internist Nicholas Parise, MD; psychiatrist William Puga, MD; and emergency doctor Herbert Wigder, MD.

Death certificate accuracy serves the greater good

The significance of a death certificate reaches far beyond the individual it describes; this document is actually one piece in the larger mosaic of national medical trends.

The information it supplies generates national and state mortality statistics, and helps public health officials assess the health of the population, identify public health problems and determine the success of medical treatments and interventions.

However, because physicians often are not trained in filling them out, mistakes and missing information can result in death certificates that are less useful to researchers and statisticians, said Steven Perry, deputy state registrar of the Illinois Department of Public Health.

"Often, physicians will write the cause of death as 'heart failure' or 'respiratory arrest,' but that doesn't really say anything," Perry said. "We need the physician's best diagnosis of exactly what caused the death."

Physicians are responsible for filling out the two parts of the certificate related to cause of death. The first line of Part I asks for the immediate cause of death; the next three lines ask for a description of its underlying causes (the diseases and injuries that set off the chain of events leading directly to the patient's death).

"Physicians often state immediate and underlying causes of death in reverse order," said Perry. "They should be careful to state only the *immediate* cause of death in the first section of Part I. They should also put only one cause of death per line – never enter two causes on the same line."

In Part II, physicians are asked to list all other important diseases and conditions present at the time of death but that did not lead to the underlying cause of death.

The 34-page Physicians' Handbook on Medical Certification of Death, published by the U.S. Department of Health and Human Services, provides guidance to physicians in filling out the cause-of-death section. Eleven case histories are used to illustrate the difference between immediate and underlying causes of death.

Among those examples are the following case history and the related entry on the death certificate: A 34-year-old-male was admitted to the hospital with shortness of breath. Tests confirmed the patient was HIV-positive.

A transbronchial lung biopsy performed by bronchoscopy was positive for Pneumocystis carinii pneumonia, indicating a diagnosis of AIDS. The patient eventually died of pneumonia.

The death certificate should list the immediate cause of death as Pneumocystis carinii pneumonia and the underlying causes as acquired immunodeficiency syndrome and HIV infection.

Perry acknowledged that knowing the exact cause of death can be difficult for a physician who is not closely familiar with the patient's history. "In cases like that, physicians should write in what they believe is the probable cause," Perry said.

Some free resources are available for physicians who would like help in filling out death certificates. The Physicians' Handbook on Medical Certification of Death, a pocket pamphlet, is available from the National Center for Health Statistics; call (301) 436-8500. Also, IDPH has laminated cards that detail the steps physicians should take and the information they should provide in completing the certificate.

For a copy of the laminate, or for more information about death certificates, call Jan Surratt in the state registrar's office at (217) 782-6554. ■

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BANNER YEAR FOR HEALTH CARE

Physicians and patients fared well, legislatively speaking, during the recently concluded session of the Illinois General Assembly, thanks to ISMS' dedicated lobbying efforts.

"Several crucial bills that ISMS was working on passed during this session, and the results are going to make life a lot easier for physicians and patients," said ISMS President Clair Callan, MD. Health care-related bills that successfully made their way out of the legislative chambers and to Gov. George Ryan for his signature include managed care reform, prompt payment and credentialing.

However, the legislative success stories include both the ISMS-backed bills that the General Assembly approved and Gov. Ryan will soon sign into law as well as the legislation that ISMS successfully blocked, noted Dr. Callan.

The chart below provides highlights of ISMS' 1998-1999 legislative efforts.

ISMS-SUPPORTED BILLS THAT PASSED

Bill	Summary
Managed Care Reform and Patient Rights Act.	This bill ensures that patients enrolled in managed care plans have basic rights (see story on page 1).
Prompt payment.	Insurance companies and HMOs must pay clean claims for health care services within 30 days or pay 9% interest.
Credentialing.	All health plans must use a standardized form for credentialing and recredentialing physicians and collect credentials data at one time.
Hospital medical staff closing.	Hospitals must inform applicants and preapplicants of the reason for denying staff privileges.
Hospital misconduct/ liability.	Hospital boards can be sued for their decisions pertaining to medical staff that are found to be willful or wanton.
Truth in health professional ads.	Licensed health care professionals must use their titles or authorized initials in every advertisement for services.
End triplicate prescription forms.	Eliminates the trip script forms. Creates a controlled substance prescription monitoring program with a central repository for collecting information on dispensing Schedule II drugs.
Automated External Defibrillator Act.	A physician licensed to practice medicine in all its branches is considered a trained AED user and is exempt from certain civil liability.
Allied health professionals.	Allows for the advanced practice of nurse anesthetists who work in collaboration with an anesthesiologist or physician.
Clinical trials.	Accident and health insurance will include an offer to cover routine patient care for enrollees participating in approved cancer research trials. The base coverage offer must be at least $10,000 annually.
Accident victim's test results.	Hospitals must disclose blood and urine test results to law enforcement officials upon their request.
Illinois Department of Public Aid budget.*	Physician services will receive a 1.6% cost-of-living increase. An additional $10 million is included for physician payment rate hikes. Increases take effect July 1.

* Signed by governor

ISMS SUCCESSFULLY OPPOSED THESE BILLS

Bill	Summary
HMOs' managed care bills.	The HMO industry introduced three separate bills as their solution to managed care reform.
Medical Disciplinary Board vote.	The two members of the public that serve on the board would have been given the right to vote on physician disciplinary matters.
Medical practice profiles.	The public would have received access to a toll-free number to obtain individual physician profiles that included criminal charges, disciplinary actions, hospital privilege revocations, medical malpractice settlements and judgments.
Universal health care.	Two bills were introduced to give Illinoisans universal access to a full range of preventive, acute and long-term health services.
Birth center licensure.	This bill would have allowed 10 stand-alone birth centers in Illinois that did not offer life-saving resources needed in critical circumstances.
Immunizations/ conscientious objections.	Parents could have objected to their children receiving health exams or immunizations based on a conscientiously held belief.
Medical malpractice coverage/liens.	One bill would have required physicians to carry a minimum of $1 million in malpractice insurance coverage. Another would have lumped all medical providers' liens together and offered them one-third of any settlement award. A third bill would have authorized prejudgement interest on medical malpractice awards.
Physician charges disclosure.	Physicians would have been required to disclose the amount of charges, which had to equal 90% of all final charges, before requesting authorization by the patient for a treatment plan.
Physician billing prohibition.	Physicians would not be able to bill HMO enrollees for amounts other than copayments, deductibles, or fees for services not covered by the HMO.
Medical Fraud Enforcement Act.	Fines imposed for medical fraud would be deposited into a special fund to be used by the Attorney General to combat medical fraud.
Domestic violence treatment notice.	Health care professionals and certain social service agencies would have to notify the police of their treatment of domestic violence victims or face criminal penalties for noncompliance.

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EDITORIAL

What does ISMS do for an encore?

In the words of crooning chairman Frank Sinatra – if he were to review this past legislative session from a health care perspective – "It was a very good year." There likely would be little disagreement with Ol' Blue Eyes from Illinois' physicians and citizens, who were treated to a medley of new health care protections in the 1999 legislative session.

A sampling (details are provided on page 3 of this issue) of the good things that emerged: patients with chronic conditions will have streamlined access to specialists; physicians' mouths will not be gagged from informing patients about all available treatment options; health insurers will not be allowed to dawdle in delivering the money they owe physicians – they face a 9 percent annual interest payment if they do.

Although passage of these monumental actions was condensed into the final few weeks of the session, these achievements were no overnight sensations.

A comprehensive managed care patient rights bill was initiated by ISMS four years ago and reintroduced every year thereafter. ISMS was there every step of the way, fighting a long and hard battle.

Over these past four years, ISMS consistently and thoroughly worked behind the scenes to steer this bill to success, testifying at all the hearings held on this matter and commandeering negotiations with opposing interests.

The health care victories won this year are the result of a longstanding ISMS policy to maintain a strong physician lobbying presence in the state Capitol.

ISMS members are to be congratulated for building the Society into one of the most respected and influential forces in Illinois. Although our political strength is sometimes cast as a negative by those who would rather not ensure quality health care for Illinois' citizens, the patients and physicians benefitting from these measures no doubt see it differently.

The Society not only steered wonderful bills to passage, it also was responsible for blocking some very dangerous ideas, including three managed care proposals sponsored by the HMO industry; proposals to mandate universal health services, physician charges disclosure and physician profiling; and a plan to prohibit physicians from balanced billing.

What does the future hold for health care legislation? As the gavel pounded the close of this spring's legislative session, discussions at ISMS were already under way, mapping out next year's plan to earn protections that were compromised out of the managed care bill so that it could pass.

The Society needs the support of all Illinois physicians to remain a driving force in Springfield. As Frank would say, "The best is yet to come."

PRESIDENT'S LETTER

Advocacy, the Internet and you: A strong combination

Clair Callan, MD

"We have been very successful in advocating for members this past legislative session."

Every survey the Society has conducted in recent years strongly suggests that advocacy is the No. 1 initiative you want ISMS to promote. Well, we have been very successful in advocating for members this past legislative session, achieving victories that will benefit all physicians, including those who have left ISMS and those who have yet to join.

These victories are excellent examples of why physicians need ISMS and why we need to convince our absent colleagues to join us. Numbers do count, and the more physicians interact with their legislators, the more successful we will be.

I hope that by now you have heard how both the credentialing and prompt-payment bills passed the General Assembly and were signed by the governor. Both of these legislative successes will have a major impact on your practice, increasing the time you can spend on patient care. Here is a brief summary of these new laws and several other important bills that also were dealt with successfully.

Credentialing. This bill requires health care plans to use standardized forms for credentialing and recredentialing physicians beginning July 1, 2000. Health plans must collect credentials data from physicians only once. The physician will fill out the standardized form one time and send copies to all of his or her plans.

Prompt payment. This bill requires insurance companies and HMOs to pay claims in a timely fashion. ISMS negotiated the following provisions: claims for due proof of loss to health care services MUST be paid in 30 days and initial capitation payments must be made within 60 days of the effective date; automatic interest payments of 9 percent will be levied on late payments.

Managed Care Reform and Patient Rights Act. This bill ensures that patients in managed care plans have basic rights. The version that passed prohibits gag orders by managed care companies and allows better patient access to emergency care and specialists.

Patients are also assured of the right to choose the participating physician responsible for coordinating their care.

In addition, plans are now required to provide more detailed information to enrollees and prospective enrollees. Another important feature of this bill is that enrollees may appeal denials to an external independent physician.

Although it does not include everything we had hoped for, it is a very good start. Several bills were defeated:

Medical practice profiles. This invasive legislation would have set up public profiles on persons licensed under the Medical Practice Act, providing such information as hospital privilege revocations, medical malpractice awards and criminal charges. This format provides no opportunity for follow-up of charges that were dismissed.

Immunizations. This bill would have given parents the right to opt out of mandatory immunizations for their children based on conscientiously held beliefs. Just imagine the havoc this bill could have raised if passed! In Illinois, where there have been outbreaks of pertussis among nonimmunized populations, we could have seen dramatically increased infections if a larger percentage of children had not been vaccinated.

Hospital records/charge fee limits. This bill, which limited medical record copying fees, was promoted by the trial lawyers. ISMS negotiated a compromise that includes allowing for a $25 handling charge.

I hope these successes are important to you. They prove that your ISMS leaders and lobbyists work tirelessly on your behalf. I also hope that you will take an active part in the legislative agenda. Next time you visit the ISMS Web site (www.isms.org), click on "Physician Advocacy," then on "Legislative Grassroots Action Center." See how simple it is to send an e-mail asking representatives to support a bill or thanking a legislator for votes that helped our cause. And if you're not online yet, call the ISMS Division of Governmental Affairs, (800) 782-4767, to ask for assistance in contacting a legislator.

Coming soon: Caution advised in vaginal birth after C-section

ISMIE Update

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Oct. 20, Northbrook

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Prevention initiatives shield patients from physical suffering, physicians from legal pain

BY JEFF BLACK

Remember Willie King? Surgeons certainly do. In fact, he probably stars in their worst nightmares. In 1995, King won a $1.2 million judgment when a Tampa, Fla., surgeon amputated his foot – the wrong foot.

Oh, that Willie King.

The media fell on the story with a vengeance, a tragic tale that not only opened the medical community's eyes, but became fodder for discussion in editorial pages and around water coolers. It also provided effective ammunition for opponents of tort reform.

The Florida incident was not an isolated one. According to the Physician Insurers Association of America, of which ISMIE is a member, in the 10 years ending in 1995 there were 225 orthopedic wrong-site surgery claims among its 110,000 physicians, with patients winning monetary settlements a whopping 84 percent of the time.

In an equally sobering PIAA statistic, over the course of a 35-year career, it was predicted one in four orthopedic surgeons specializing in skeletal operations would perform surgery on the wrong site.

The situation clearly demanded attention and action. In 1997, the Rosemont-based American Academy of Orthopaedic Surgeons provided both. S. Terry Canale, MD, currently first vice president of the 17,000-member AAOS, headed a task force that studied wrong-site surgery. "It's a preventable problem," stated Dr. Canale, an orthopedic surgeon in Memphis, Tenn., "but a devastating one if it happens to you. Given the total number of surgeries, it's rare. Still, there's no legal defense. It's an almost automatic payout."

The task force determined that operating on the wrong anatomical site is the result of an increased number of elective surgeries, poor preoperative planning, lack of institutional controls, surgeon carelessness and a breakdown in patient and surgeon communication.

Dr. Canale said the sheer number of people involved in presurgical and surgical procedures is a mitigating factor. Everyone thinks someone else will identify the surgical site. "With so many people, no one takes a personal interest. Any time a surgeon delegates authority, he increases the chances a wrong-site surgery will occur."

The AAOS task force also discovered that its Canadian counterparts at one time had the same problem. But, Dr. Canale said, they managed virtually to eliminate the problem.

The method the Canadians used – and one that in 1998 the AAOS urged its members to adopt – was the "Sign-Your-Site" initiative. Aimed at reducing patient suffering and sparing physicians brutal litigation, the education program asked all surgeons literally to mark with indelible ink on the patient's body the operative site as a part of their presurgical routine.

According to Dr. Canale, the preferred markings are the surgeon's initials. Such a symbol forces surgeons, now clearly responsible, to focus on the exact site, as well as address any questions or problems prior to surgery.

Recently, Rush North Shore Medical Center in Skokie went even further. Marked surgical sites are just one item in a series of checklists required at various points prior to surgery. Douglas Norman, MD, a thoracic surgeon and chairman of the hospital's Department of Surgery Performance Improvement Committee, led the team that eventually devised and instituted the new policy.

Conceding that it's likely that many surgeons have experienced instances in which the wrong surgical site was prepped or a misplaced incision was nearly made, Dr. Norman added, "Unfortunately, carelessness can happen to anyone. Memory can get fuzzy. Especially in those cases in which it's been weeks since the surgeon has actually seen the patient in his or her office. Or perhaps the surgeon has never seen the patient at all."

Dr. Norman explained that there are known circumstances in some institutions in which primary care physicians schedule surgery, with the surgeon not involved until he or she actually walks into the OR. It's a situation about which he has real concerns and that, he hopes, is occurring less.

"It amazes me that any surgeon would turn up on the day of surgery without having seen the patient," he said. "It's crazy in this litigation era. You have to see the patient. Whether in your office or in the holding area outside the OR, you should always meet the patient and family and explain your procedure appropriately."

The new Rush North Shore policy, in place for about six months, states that at four separate points on the path from scheduling to the OR, specific steps must be taken.

▮ **Scheduling surgical procedures** – The proposed surgical site must be clearly identified on the scheduling form, with an emphasis on the word "clearly." Illegible forms are rejected. The words "right" and "left" must be spelled out completely. Abbreviations are not accepted.

▮ **Preoperative inpatient or outpatient verification** – If no side has been appropriately identified, the surgeon is called, and a new or corrected form is required. Consent forms are verified with the surgery schedule. Discrepancies or uncertainties result in a call to the surgeon for clarification. Communication barriers – sight and hearing impairments, a non-English-speaking patient – as well as the patient's emotional status are noted in order to document his or her ability to participate fully in preoperative discussions. There have even been cases where the patient was confused, insisting on the wrong surgical site.

▮ **Preoperative holding area** – A registered nurse rechecks the operative site, checklist, operative schedule and informed consent with the patient. If there is any discrepancy, POH staff contact the surgeon. The recommendation is that the intended site be identified with a marker by the surgeon, or his or her designee. Only after the surgical site is thus confirmed can the patient go to the OR.

▮ **Operating room** – The circulating nurse in the OR asks and confirms the planned procedure and surgical site with the surgeon. This verification is documented on the operative record. If questions cannot be resolved, the patient is returned to the POH. All pertinent X-rays are required in the OR during surgery.

All in all, Dr. Norman said, the new policy is "a matter of documentation, and should not be a major paperwork matter. The surgeons and hospital personnel feel much more at ease with the system in place, knowing that it serves our patients best and protects us all from unfortunate preventable errors."

On the first anniversary of its sign-your-site initiative, the AAOS reported results of a member survey indicating more than 88 percent of respondents believed wrong-site surgeries would be prevented by the new program. Forty-five percent said their hospitals have now instituted a similar policy.

Dr. Canale said that "to get that number of people in just one year to change their schedules, adapt their behaviors and use new tools is a real milestone."

He added, though, that he's heard some surgeons argue a sign-your-site program is impossible for them because their schedules are too full. They complain they don't have time to sign an operative site or implement new procedures.

Dr. Canale scoffs at such a response. "That whole 'I'm too important to see the patient' attitude is what gets me," he said. "When I hear that, I think, 'That's exactly the type of surgeon we're trying to save.'" ■

Reform

(Continued from page 1)

president of the Illinois College of Emergency Physicians and past chairman of its government affairs committee. ICEP has lobbied for five years to have the prudent layperson standard adopted. When ISMS spearheaded MCRPRA this year, ICEP gladly joined the effort, she said.

This time, legislators were receptive to the issue. Some had their own emergency room horror stories. Others, like MCRPRA cosponsor Sen. Thomas Walsh (R-LaGrange Park), visited emergency departments, where they saw scenes that Dr. Nedza said are all too familiar: a patient who has been in a car accident calling her insurer prior to treatment to see if she is covered for an emergency room visit, or a patient who has received emergency room care for his chest discomfort subsequently learning that his insurer will not cover the visit because he had a case of heartburn.

Patient access to the proper care should be easier now that managed care plans must inform their enrollees of their complete coverage terms, Dr. Callan added. And, if the plan will not cover a particular treatment, the patient must be informed of the avenues for an appeal. As a result of such provisions, patients discussing treatment options with their physicians will know whether the plan covers those options.

Due to the act's requirement that plans give providers and their patients a 60-day notice of the doctor's termination from the plan, patients will be spared from an abrupt cessation of care, Dr. Callan said. Those patients can continue to receive ongoing treatment from their physician for 90 days.

An end to gag clauses is significant because it allows a physician to fully discuss different treatment options with the patient without the fear of retribution from the plan, Dr. Callan noted.

Another ISMS-generated improvement over the current system allows enrollees who need ongoing care for chronic conditions to apply for a standing referral to a specialist.

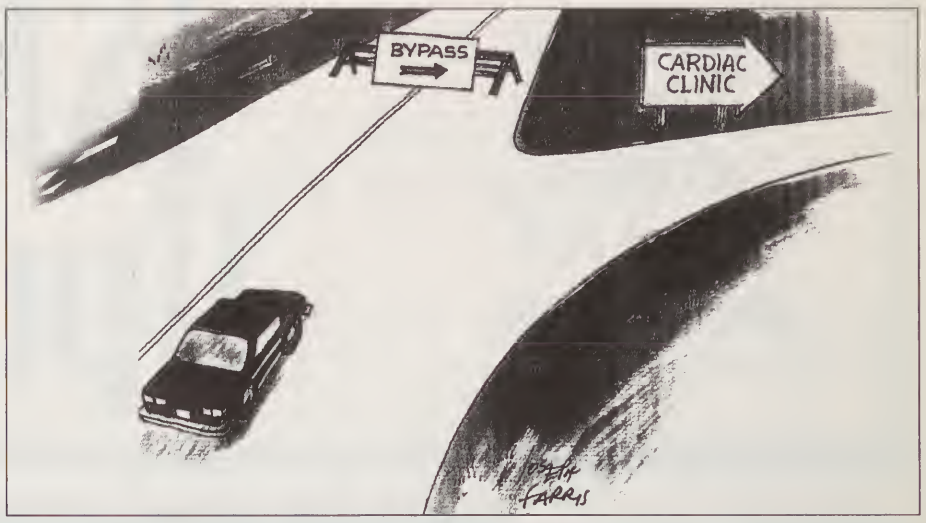
People with chronic illnesses view their specialist as their primary care physician, and they should not have to "jump through hoops" every time they need to see that specialist, said Jim Duffett, executive director of the Campaign for Better Health Care, which has main offices located in Champaign and Chicago.

Guaranteeing that patients have access to specialty care is also essential to specialist groups. Orthopedic surgeons had lobbied hard to make easier access to specialists part of MCRPRA, said Richard Geline, MD, ISMS immediate past president and an orthopedic surgeon in Skokie. Although the orthopods did not get everything they wanted, the "compromise" provisions of MCRPRA will mean that patients face fewer restrictions to obtaining the specialty care they need, he added.

In general, some networks may not have a practitioner with the desired degree of expertise available to treat patients who need to see a specialist for scoliosis surgery or a total joint revision, said Dr. Geline. "If the plan doesn't have the services available in its network, it will have to go out of its network to find a specialist who can provide the needed care," he said.

Dr. Geline said orthopods also applaud the utilization review requirement that calls for qualified outside reviewers to examine proposed medical services or procedures. Plans cannot arbitrarily deny those services or procedures, Dr. Geline said, adding that they will be required to make timely decisions based on sound scientific evidence.

Both Drs. Callan and Nedza believe that physicians must remain vigilant so MCRPRA will be properly implemented. "Insurers need an incentive to follow through and make changes that include updating their coverage policies, and patients must be educated about what the law means for them," Dr. Nedza said. ■



GUEST EDITORIAL

Quality indicators: A map for physicians

by A.S. Maurer, MD, and Julie Standerfer, RN, MS

The process of monitoring quality in our nation's nursing facilities entails two consistent components. First, every certified nursing facility in the United States uses the Minimum Data Set, a standardized resident assessment form. Second, these forms are required to be electronically submitted via the Internet to the Health Care Financing Administration at least monthly.

There is a gold mine of information inherent in the MDS, from care planning to measurement of outcomes; due to the Balanced Budget Act of 1997, it is also intrinsically tied to Medicare reimbursement. In its original form, however, the MDS is difficult to digest and reflects only individual clinical status.

To unlock the information inside the MDS, the government contracted with University of Wisconsin researchers to isolate "quality indicators" – categories of clinical outcomes and conditions derived from the MDS. Quality indicators represent nothing less than magic to physicians and nursing facility staff. They provide a tool that helps guide resident-care decisions, chart best practices and analyze care trends throughout a facility or a targeted population.

After identifying the 30 quality indicators, the researchers' next step was creating computer software that automatically turns the MDS into measurable quality indicators. Currently, more than 100 Illinois facilities are using the American Health Care Association's facilitator quality management system. The national database, fed by its users, is kept in real time. This means that quality monitoring is not just a one-day snapshot anymore. Now, the sample of data is large enough to provide an accurate picture with which to compare each facility. Physicians, physician-educators and researchers are able to review data to help long-term care physicians practice medicine that will work for years to come.

Think of the MDS as the road, and quality indicators as the map. Once a physician can read the map, he or she is more free to move through treatment plans. By tracking trends within a facility, physicians will be able to link related outcomes together. For example, physicians can analyze if certain residents are having similar problems. If a group of residents is experiencing more falls or increased incontinence compared with their counterparts in the facility, and they are all triggered by the quality indicator "use of nine or more medications," an explanation for the problem might have been uncovered. If not, the physician may have to search further, but either way he or she is able to better isolate and formulate a plan that corrects the trend.

Of course, prescribing nine or more medications is not in itself wrong, and there is no law that prohibits such a prescription strategy to an elderly patient with various diagnoses. Quality indicators, however, can help a physician ascertain whether certain methods might actually be doing more harm than good. Suppose, for example, that your long-term care residents at Facility X are measuring low for "use of 9 or more medications." That is not necessarily a positive sign. Other facilities around the nation might change their own care practices, which might cause a meteoric drop in levels nationwide; then your quality indicator will appear stagnant, and your treatment may be deemed excessive. Physicians can use quality indicators to compare their facilities with others throughout the county, state or nation.

Quality indicators will impact the survey and regulatory process as well. For example, HCFA recently announced that a revised survey process will be piloted in 1999 using quality indicators for nutrition/hydration and pressure sores. Quality indicators will create a new breed of "desk surveyors," meaning surveyors won't have to leave the office to decide time of survey, frequency of survey, and number of surveyors dispatched. Quality indicators may also be proof enough to warrant a deficiency.

While quality indicators may be a double-edged sword, it is obvious that their use in nursing facilities will bring about much more good than harm. As a tool for the modern physician, quality indicators may help us solve complex problems that have plagued the geriatric population for decades.

A.S. Maurer, MD, is Associate Professor of Clinical Family Medicine at the University of Illinois College of Medicine, Peoria. He is a member of the Illinois Health Care Association Quality Improvement Committee, and holds a long-term care administrator's license.

Julie Standerfer, RN, MS, is Clinical Coordinator for the IHCA. ■

Courtesy

(Continued from page 1)

outlines its position, as well as HCFA's guidelines on fraud and abuse.

The AMA's policy affirms a physician's right to provide professional courtesy, which is a long-standing tradition, but notes that it is not an ethical requirement. Physicians are advised to use their own judgment in deciding whether to waive or reduce fees when treating fellow physicians or their families. The AMA's professional courtesy policy is rather vague, said Dr. Danehower, who would prefer that any organized medicine policy on this matter strongly support the principle.

The AMA advises physicians to use caution in extending professional courtesy.

In addition, the AMA's policy issues the following words of advice to physicians who intend to waive copayments:

• Accepting insurance payments while waiving patient copayments could violate the policies of some insurers, while others will allow copayments to be waived if they know the reason for waiving the fee.

• Routine forgiveness or waiver of copayments may constitute fraud under state and federal laws. For instance, if a physician extends professional courtesy to a Medicare recipient and bills the insurer without attempting to collect the copayment, that action violates the Medicare program's regulations. The physician should also discount the amount the payer is billed.

Moreover, waiving copayments for reasons other than economic hardship could violate state or federal laws.

Extending professional courtesy can be viewed as a violation of the federal antikickback law if the treating physician receives subsequent referrals of Medicaid or Medicare patients, or if regulators perceive the professional courtesy is an inducement to encourage referrals.

• The AMA advises physicians to use caution in extending professional courtesy to ensure that copayment policies comply with state and federal laws and meet the patient's insurer's requirements. ■

Cost

(Continued from page 1)

"There should be no more than a 4 percent increase, and that will be spread out over 10 years," Dr. Callan said, using data obtained from an analysis performed by the Congressional Budget Office.

The CBO study, conducted in July 1998, examined the fiscal impact of a federal patient rights bill that is more expansive than the legislation recently approved in Illinois.

Although not identical, the federal legislation does contain several provisions similar to Illinois'.

These include: providing patients with easier access to specialists, ensuring that patients have continuity of care if the physician leaves the plan and making grievance procedures available to patients.

In addition, an ISMS analyst noted that managed care plans that already are making reasonable coverage decisions should not incur additional costs because they will not be required to do anything differently from what they do now.

Regarding specific MCRPRA provisions and the concerns expressed by insurers and businesses, the analyst made the following observations:

• The provisions that allow for a broader choice of pharmacies will not increase the cost of drugs.

HMOs will set the terms and conditions of the agreement, including price, and if a pharmacy can't meet those standards, the plan does not have to contract with that pharmacy.

• During a transition-of-care period, enrollees can continue to receive care from a physician who leaves the plan as long as the physician accepts the HMO's rates and follows the plan's utilization review protocols.

• The external appeals process should not increase costs if reasonable decisions are currently being made internally – coverage and payment decisions that are based on sound clinical guidelines implemented by licensed health care professionals. In such cases, there would be few appeals.

• Plans must comply with Utilization Review Accreditation Commission regulations that include establishing a reasonable appeals process and ensuring the appropriate use of health care professionals making decisions.

They do not need to obtain URAC accreditation; this provision should increase costs minimally. ■

Positions and practice

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Home Physicians, an innovative medical group located in Chicago/northwest Indiana and specializing in house calls, is seeking physicians to join its practice. We are looking for individuals with training in primary care/surgical debridement. Full- and part-time positions available. Please fax CV to Scott Schneider at (773) 384-7053 or mail to Home Physicians, 1735 N. Ashland Ave., Chicago, IL 60622. Call (773) 292-4800.

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IDPR DISCIPLINES

April 1999

Walter R. Gonzalez, Urbana – physician license reprimanded and fined $1,000, and controlled substance license placed on probation for two years, for failing to keep records supporting his prescriptions for controlled substances relating to one patient.

Robert Edward Gulley, Westchester – physician and surgeon license indefinitely suspended for failing to file income taxes and pay a previously owed tax liability.

Maudie Miller, Alton – physician and surgeon license reprimanded and fined $5,000 for failing to properly diagnose a breast lump which was found to be cancerous and failing to grant the patient's request for a biopsy of the lump in a timely manner.

Hector Olivia, Chicago – ordered to cease and desist the unlicensed practice of medicine.

Zachary Taylor Powell, Chicago – physician license placed on probation for one year, and controlled substance license indefinitely suspended, for prescribing over 3,500 doses of Fioricet with Codeine during 1996 and 1997 to himself and his wife and for not establishing proper records of patient care.

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

Seminar to address physicians' labor unions

The Chicago Health Executives Forum is sponsoring a program in Chicago on July 15 that will review physician unionization developments both nationally and locally.

The program will begin at 6 p.m. with an hour of refreshments and networking. Following, an hour-long presentation will examine the underlying motivation for physician unionization; regulatory and legal implications of unionizing; and the impact on hospitals, physicians and managed care organizations.

Cost for the event is $35 for CHEF members, $45 for nonmembers. The program will be held at the Embassy Suites Hotel, 600 N. State St., Chicago.

The seminar is part of CHEF's ongoing initiative to provide area health care managers with educational opportunities. To register, or for additional information, call (847) 256-9454. ■

DEA

(Continued from page 1)

Joseph Murphy, MD, 2nd vice president of the ISMS Board of Trustees, who also wanted to ensure that DEA numbers are used appropriately.

The adopted resolution calls on ISMS to do the following:

- Seek state legislation to prohibit the use of physician DEA numbers except to prescribe and procure Schedule II drugs.
- Remind all physicians of the AMA's position on the appropriate use of the DEA number.
- Ask the state to advise pharmacists and third-party payers of the appropriate use of DEA numbers.
- Request that the AMA inform physicians, pharmacists and third-party payers nationally of the appropriate use of DEA numbers.

The education component of the resolution is important, said Dr. Danehower. "Pharmacists, insurers and others just don't understand that the DEA number should not be given out, and we have to let them know."

The AMA's positions on confidentiality and misuse of the DEA number include:

- The DEA should not divulge a physician's DEA number unless there is a valid reason.
- Insurance and pharmaceutical companies should use a physician's state medical license number rather than DEA number to identify a physician in the computer files when controlled substances are not involved.
- The AMA will develop model legislation to restrict the use of the DEA number to monitor the prescribing of controlled substances only.
- The AMA will explore measures such as legislation and regulation to discourage or prevent insurers and others from using physicians' DEA numbers as identifiers.

Dr. Danehower said the DEA number issue has become a catch-22. ISMS and the AMA tell physicians not to give out their DEA numbers except for controlled substance prescriptions, but insurers and others insist that physicians provide those numbers for identification. "It's time to straighten this out," he said. ■

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WHEN IT MATTERS MOST

ND UNIONS: QUESTIONS ANSWERED (PAGE 11)

Illinois Medicine

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Vaginal birth after cesarean: Deciding when

PAGE 6

Have you met OSHA standards?

PAGE 2

Collective bargaining train leaves the station

Society finds an ally in the AMA

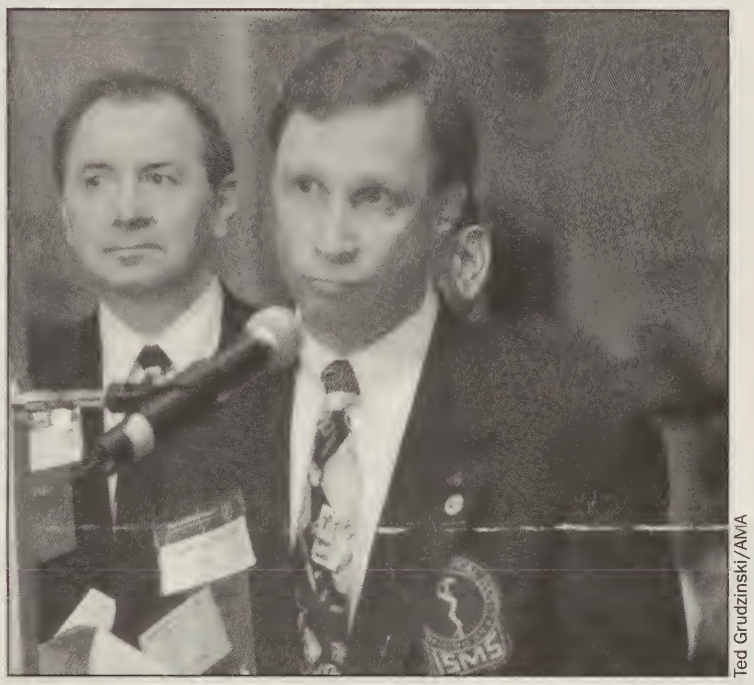
BY PAULA KRAPF

Now that the American Medical Association has adopted a proposal to form a national negotiating organization for employed physicians and residents, ISMS is likely to have a partner to assist the Society in its own effort to form a collective bargaining unit.

Both measures came at the urgent behest of each organization's House of Delegates Annual Meeting. Although each organization must now navigate foreign terrain, they may be able to combine forces and gain more clout – something that physicians sought in the first place. "We're all sending a message that something has to be done to allow physicians to have representation," said ISMS President Clair Callan, MD.

The timing is right for state medical societies and the AMA to work together on this issue, Dr. Callan said. The actions taken by ISMS and the AMA complement each other, she added. Because states including Florida, California and New York have already done extensive research on the issue of physician negoti-

(See AMA, page 11)



Ted Grudzinski/AMA

ISMS delegate Marc Schlesinger, MD, successfully proposes an amendment at the American Medical Association Annual Meeting ensuring that the Association educate physicians about the limitations and advantages of a national negotiating organization.

ISMS sets off on journey to explore joint negotiations

BY PAULA KRAPF

ISMS has embarked on the long and complex road to form a physician collective bargaining unit, beginning with research and educational activities to be conducted over the summer.

The ISMS Board of Trustees unanimously voted June 12 to fund a multipronged campaign that includes educating members about the issue and pursuing state and federal legislation to support the initiative. (See chart, lower left.) "This is what our membership wants right now," noted Janis Orlowski, MD, ISMS secretary-treasurer.

To get the ball rolling, the Society will mail a survey to members this summer to gain their input and ideas. Although ready to launch an exploratory process, trustees acknowledged the Society is entering this endeavor cautiously, and there are many obstacles to overcome. "There is no perfect model to emulate that guarantees success or that is representative of physicians as a group," said ISMS General Counsel Saul Morse.

(See Train, page 10)

A journey of 1,000 miles begins with several steps

Here are the steps ISMS will take to determine how to offer a collective bargaining unit to physicians.

- **Earmark funding from the Society's permanent reserves to cover startup exploratory costs of the collective bargaining unit, including member education, legal services and research.**
- **Explore whether ISMS should create a separate entity to serve as the umbrella organization to oversee implementation of the collective bargaining unit.**
- **Conduct comprehensive educational research and survey efforts to alert ISMS members to the effort. Solicit grassroots physicians' support for the initiative through mailings and survey research.**
- **Invite county medical societies and Illinois specialty groups to join the initiative by providing financial aid and soliciting local physician support.**

New laws could pave the way

Lobbying for federal and state legislation that would tear down the antitrust barriers to physician collective bargaining is another piece of ISMS' strategy.

The concept is not new. In fact, 13 years ago ISMS introduced state legislation that would have created an exemption to federal antitrust laws that prevent physicians who practice independently from negotiating jointly with HMOs and PPOs. The legislation failed due to fierce opposition from business and insurance interests.

"ISMS could again attempt legislation to deal with terms of service, the terms of the relationship with managed care organizations and employees as well as levels of pay," said ISMS General Counsel Saul Morse.

In addition, the climate at the state and federal level may become more favorable to physicians gaining collective bargaining powers as the general work environment evolves. More businesses are outsourcing and more individuals are choosing to work at home, Morse noted, changing the definition of an employee to terms that may be favorable to physicians.

Other states are taking a similar stance regarding legislative solutions to collective bargaining issues. A bill similar to ISMS' antitrust exemption legislation was adopted by lawmakers in Texas this year and was signed last month by Gov. George Bush. The Texas legislation will have the state's attorney general oversee physicians' negotiations with payers. However, the Department of Justice and/or the Federal Trade Commission have indicated that they may challenge the Texas law, said Morse.

On a national level, U.S. Rep. Tom Campbell (R-Calif.) has introduced the Quality Health-Care Coalition Act. The act

(See New laws, page 11)

INSIDE

Protecting employees from workplace hazards

BY JOY LE VEE

Meeting OSHA standards

Like any business that exposes employees to potentially infectious or hazardous materials, medical offices have a legal obligation to protect their workers. It is up to each medical office to meet the rules for safe and healthful working conditions set by the Occupational Safety and Health Administration (OSHA) of the U.S. Department of Labor.

The health care industry gets high marks for its compliance, according to Leslie Ptak, industrial hygienist in federal-state operations, in OSHA's Chicago regional office. "It has done a tremendous job – much better than any other industry we regulate," she said. The reason, she speculated, is because health care workers already are familiar with handling contaminants.

To comply with regulations, medical offices are responsible for designating an OSHA compliance person, developing and annually updating a compliance plan and ensuring that employees follow the plan. The only exception is for independent self-employed practitioners who are not part of a corporation and who have no employees.

OSHA standards for physician offices generally apply to hazard communications and employee exposure to bloodborne pathogens. Additional standards exist for certain specialty practices, such as those that conduct laser surgery, or for practices that provide care for patient populations with specified diseases, such as tuberculosis.

To ensure that standards are being followed, OSHA conducts workplace inspections, which may be random, or targeted in groups. Inspections of medical offices most often take place following a complaint from an employee or a referral from the public health or fire departments or the media, Ptak said.

If hazards are discovered, OSHA compliance officers can issue citations. There are penalties for hazards that could result in serious injuries.

Upon request, OSHA provides a free packet of information that includes copies of standards, sample programs, a training checklist and other documents related to medical offices. OSHA also offers a free consultation service so employers can learn about potential hazards at their work sites and improve their occupational safety and health management systems. For additional information, call your nearest OSHA office in Illinois.

Calumet City area: (708) 891-3800
Chicago area: (847) 803-4800
Chicago regional: (312) 353-2220
Fairview Hts. area: (618) 632-8612
North Aurora area: (630) 896-8700
Peoria area: (309) 671-7033 ■

Steps for compliance

To bring medical offices into compliance with regulations regarding exposure to bloodborne pathogens, OSHA recommends physicians develop a written plan to identify tasks and procedures where occupational exposure to blood occurs.

The plan should include an implementation schedule, and should be accessible to employees and available to OSHA. The plan should be reviewed and updated at least once a year, more often if necessary to accommodate workplace changes. It should include:

- Universal precautions (treating all body fluids/materials as if infectious).
- Hand-washing facilities.
- Procedures to minimize needle sticks, splashing and spraying of blood; ensure appropriate packaging of specimens and regulated wastes; and decontaminate equipment or label it as contaminated before shipping to servicing facilities.
- Appropriate personal protective equipment such as gloves, gowns, masks and mouthpieces.
- Methods for handling contaminated laundry and disposing of contaminated sharps; standards for containers for these items.
- Hepatitis B vaccinations.
- Procedures for employees to follow after they have had an exposure incident.
- Hazard communication, including employee training as well as warning labels on containers.

Is it necessary to buy those training materials?

Many physicians are afraid of OSHA, according to George Dirkers, MD, and chairman of the ISMS Council on Medical Service.

"OSHA pays surprise visits to physician offices, and failure to meet standards can result in criminal penalties," explained Dr. Dirkers, of Midwest Occupational Medicine, with offices in Wood River and Belleville. "This scares a lot of physicians."

Taking advantage of that fear, a number of businesses sell materials and services that train physicians and their staff members in how to meet OSHA standards. Offerings include certification courses and employee training videotapes. Some companies even help doctors' offices develop complete compliance plans that include employee training and site-specific documents.

Are these services necessary? Are they worth the cost – sometimes hundreds of dollars? Promotional materials for these companies say their services and materials are well worth the expense because OSHA penalties can be up to $10,000 per infraction.

Dr. Dirkers, however, said the value of purchasing vs. self-training depends on the willingness of physicians and their staff members to undertake the project themselves. He suggests physicians give it a try.

"The OSHA packet is bulky and cumbersome, but it is written in layperson's language. Physicians can read it in just a few hours and formulate their own plan," Dr. Dirkers said.

As part of his occupational medicine practice, Dr. Dirkers has helped many corporate clients become compliant with OSHA standards. "I find OSHA helpful and responsive to calls. Their rules are pragmatic, and their reporting requirements are not that difficult to follow," he said. "Physicians need to know what to do about blood cleanup if a test tube breaks on the floor. Following OSHA guidelines leads to good patient care and protects physician liability."

Some physicians have been confused by company solicitations, especially those that use scare tactics or give the impression that there are official government mandates to purchase the materials. A number of doctors recently called the Illinois State Medical Society to question a business solicitation, which had been mistaken for an OSHA document.

Dr. Dirkers said physicians should not be duped into buying these items. "OSHA does not ever solicit," he said. "It publishes its rules and regulations, and that's where you find out what to do. It is not in the business of selling compliance, but in auditing to see that you are compliant." ■

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When dying is done right

Springfield project sees end-of-life care as a community effort

BY JEFF BLACK

Next in a series on:

Lost amid the fury of Oregon's debate over physician-assisted suicide overshadowed by the ongoing saga of Jack Kevorkian, MD, one Illinois community is moving quietly ahead with efforts to ensure its citizens experience comfortable, dignified deaths. It's a model some deem revolutionary, but one that may find increasing resonance in a culture struggling with issues concerning end-of-life care.

The Springfield-based Central Illinois Community Palliative Care Initiative is a not-for-profit organization begun in February 1998. Its goal is to ensure that all Springfield residents are valued and properly cared for while seriously ill or dying.

Initiative proponents believe palliative care, when done right, is active, comprehensive and interdisciplinary, enhancing comfort and improving quality of life. They also believe proper palliative care neither hastens nor postpones death; rather, it guides patients and families as they address issues of life completion and closure. Such care also values sufferers – unlike physician-assisted suicide, which debases and devalues them.

However, experts agree that what makes the Springfield initiative truly unusual is its reaching beyond the city's medical community to involve religious groups, government agencies and laypeople. This inclusion of "average" citizens, especially, is considered unique, and may be setting the precedent for a national model. The rationale is that end-of-life issues can't be adequately addressed if patients' needs are unsolicited and unknown. CICPCI seeks to identify specific needs and desires, and make the changes necessary to meet them.

CICPCI is the brainchild of Mary Bretscher, MD, an oncologist at Springfield Clinic who also serves as the initiative's chair. "Dying is not a medical event," she said. "It's a community event. It's a community privilege. I felt we needed in our community a joint effort involving all the stakeholders in end-of-life care." She described the initiative's goals as threefold: community education, health care-professional education and increased access to care.

The first year of CICPCI's existence was spent organizing, setting goals and gaining not-for-profit status. With those tasks completed, a survey designed to assess attitudes and needs surrounding end-of-life care was mailed recently to 1,000 Springfield-area residents. In November, the initiative will sponsor a CME program for physicians. Next year, CICPCI plans to hold "a large community convocation," Dr. Bretscher said, "a daylong conference concentrating on end-of-life issues and how the community can be involved."

The organization is also committed to holding a series of town meetings, perhaps 10 in all, at local churches. At these meetings, congregation members will participate in roundtable discussions on the subject of palliative care. Dr. Bretscher emphasized that CICPCI will be especially sensitive to minority faith communities at these meetings. She said she understands that "in the past [the medical community] might not have addressed their needs sufficiently."

"It's very exciting," said Jane Jackman, MD, ISMS past president and an initiative board member. "Dr. Bretscher has gone beyond the traditional model of addressing end-of-life issues to involve the whole Springfield community." Dr. Jackman believes the recently mailed survey will be useful "in gauging what physicians are doing right and what our deficiencies might be." She added that the survey will also help identify any public attitudes that medical professionals might have to contend with. Past opinion polls have consistently shown a majority of Americans fear a painful death, one in which they feel isolated and lacking control.

One belief – media-driven and becoming more widespread – Dr. Jackman expects to encounter is that new technology can handle almost anything. "Many people don't have a realistic view of death,"

(See Dying, page 9)

Ron Ackerman

Remaining dedicated to daily duties as well as the Springfield-based palliative care initiative, Mary Bretscher, MD, confers with Gillespie resident Walter Dobson, a nonterminal patient in her care.

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EDITORIAL

Uniting to improve patient care

The campaign by ISMS and the American Medical Association to launch collective bargaining is a proactive move that demonstrates leadership in finding innovative ways to protect physicians and patients.

But news of a physicians' "union" has been met with the inevitable comparisons with Teamsters and strikes, and criticism that doctors should rise above labor-business battles over wages.

The responsibility now falls on physicians to define the "U" word on their own terms. The public needs to be educated that this movement is not about fees and income; it is about physician autonomy and patient care. With every patient encounter, physicians must demonstrate that joining forces can help them take back control of health care decisions – order necessary tests, perform needed procedures – without being second-guessed by bean counters.

ISMS president-elect M. LeRoy Sprang, MD, speaking at the AMA union debate, pointed out that at a time when managed care organizations are telling physicians to see a new patient every 10 minutes, physicians can't afford to let any opportunity to regain some control over health care decisions slip away. "We need new tools, and this is one of the tools we need," said Dr. Sprang.

Although the collective bargaining decision is cinched, getting the system up and running is far from a done deal. Like most ventures into new frontier, obstacles make it uncertain what the final destination will be.

Who's in and who's out are major questions to resolve. As passionate as the Society is about establishing a collective bargaining unit, the reality is that current antitrust laws preclude many physicians from participating.

The Society and the AMA are gearing up to change antitrust laws that deny physicians who practice solo or in small groups the ability to negotiate jointly.

For ISMS, the next leg of this journey will be to educate members and to explore various models for structuring collective bargaining.

A survey will be sent to members this summer to solicit their input; a comprehensive member education effort will begin; county medical societies and specialty groups will be invited to join the cause; and ISMS will explore creation of a separate entity to act as the umbrella organization for this initiative.

The decision to form a collective bargaining unit for physicians is an important first step toward giving physicians a tool to negotiate for better patient services. Reaching the end of the line likely will be a long journey. Physicians should climb aboard and provide their ideas and support.

PRESIDENT'S LETTER

Physicians: Can you read your patients' health literacy?

Clair Callan, MD

"Patients with the greatest health care needs may have the least ability to read and understand instructions."

By now I hope you have all heard the good news about Illinois' recently completed legislative session. The bills that ISMS worked so long and hard to get passed – credentialing, prompt payment and managed care reform – should go a long way toward making it easier for you in your practice and freeing some time that you can spend with patients.

With that "extra" time, I ask you to think about an issue that may affect more of your patients than you suppose – one that has an impact on the potential success of the therapy you prescribe. That issue is patients' health literacy, or the ability to read and comprehend prescription bottles, appointment slips and other materials required to successfully implement a treatment plan.

Patients' knowledge (or lack of it) regarding their own health was the topic at a recent AMA leadership meeting. Startling statistics were presented from the largest study of functional health literacy conducted so far in the United States. According to that report, published in 1995, 42 percent of patients were unable to understand directions for taking medication on an empty stomach, 26 percent could not understand information on an appointment slip and 60 percent could not understand a standard consent form.

These statistics point to the fact that even patients who appear to understand everything you are saying may have some degree of difficulty grasping complex instructions about diet, medications and care. As a result, your carefully considered treatment plan may not be followed as you prescribe.

For example, noncompliant drug taking in the elderly population ranges from 40 percent to 75 percent. Some patients take many medications, perhaps on different time schedules of which they find it hard to keep track. Others may just forget or confuse what they are told. As a result, they may not be taking their medications correctly and so are at risk for either failure to respond or an increase in severity of their disease.

Even younger patients may experience difficulty following your orders. Patients with the greatest health care needs may have the least ability to read and understand instructions given to them about their medications.

Still others may have difficulty understanding what their clinical condition is or the importance of following directions. They may be afraid to ask questions if they don't understand what you are telling them, because they don't want to appear stupid.

Poor health literacy can have a negative impact on a person's health for a number of reasons. For one thing, patients who do not understand commonly used medical terms may not be able to give an accurate medical history. Also, with the readability level of most informed consent forms at the college or graduate-school level, the signature of a low-literacy patient on that form may not indicate informed consent at all.

And with managed care now a fact of life, patients are increasingly required to do such things as manage their own chronic conditions more often, properly use but not overuse the emergency department and, in the case of asthma patients, select and correctly use inhalers. A patient with low health literacy can easily be overwhelmed by these tasks, which to us seem so simple.

As physicians, we can do a lot to improve the health literacy of our patients. We can try to make sure that patients understand what we are saying when we are talking to them. Communication is so important, and it is a two-way street. Good communication takes time and extra effort. Patients rely on their physicians to tell them what to do. They trust us to do the right thing for them.

Please think about this and about those patients who may need some extra time with you and your staff to fully benefit from your treatment plan. You will be pleased with the results.

GUEST EDITORIAL

How physician practices can learn from peers in other fields

by Thomas L. Bookey

In the last decade, the practice of medicine has changed in ways few anticipated. Managed care, government intervention, and for-profit hospitals have altered what was once a service profession into a service business. The demands on medical practices are migrating from juggling only the needs of the patients to running a business.

Traditional industry – those businesses with an actual product sold to consumers or other businesses – learned long ago the need to have some executives manage the business while other executives operate it. In medicine, the physician has been both CEO and COO.

Physicians are not alone. Medicine is only the latest service industry facing the realities of managing a business as opposed to serving "clients." Many other service professionals have been forced to evolve into business managers in addition to plying their trade. The legal, banking and accounting industries all have reinvented their operations. Even utility companies – another industry whose fees are regulated as closely as the medical community – have been forced to change to survive in a competitive marketplace.

Unfortunately, the three largest issues for medical practices today – managed care, overhead and personnel management and malpractice – are not likely to disappear. One can examine what other industries do when facing significant and long-term change.

In most cases, America's companies have turned to consultants to help them understand the long-term outlook of their business, the best way to increase margins and better service. Consulting firms have played an integral role in increasing worker efficiency, streamlining management and controlling costs. At the same time, consulting firms are often too costly and time-consuming for a medical practice. In short, traditional consulting firms are an unrealistic solution for most medical practices.

An alternative to management consulting has arisen among small businesses that offers management expertise in a cost-effective manner – peer group consulting.

Peer group consulting brings together key decision-makers in different industries to provide real-world, tested, immediate business expertise and solutions. Peer group consulting has several different faces – membership-based organizations, executive roundtables and industry leader think tanks. In all cases, true peer group consulting offers hundreds of years of real experience in business and management in a real-time setting. You've heard the phrase, "Been there, done that." That's the basis of peer group consulting.

The success of a practice often depends on outside forces – the insurers one contracts with, the local hospital's desire to control its physicians' practices, government's insistence on regulating and "controlling" medical costs and the whimsy of employers who change health care plans. How can your practice group navigate the ongoing business decisions, contracts, negotiations and pitfalls? Look around the table at your peers who have been through similar wars with their suppliers, customers and partners.

Are you afraid of losing your best nurse because of higher pay at a nearby hospital? You can be sure others at the table have seen this before and have ideas of what worked – and what didn't – for them.

Are your fees being squeezed by an aggressive insurer? The president of the small firm sitting across from you can offer ways to leverage your relationships with a large number of patients at a local corporation.

Struggling with high overhead in an era when fees are less flexible? Faced with a revolving door of nursing and administrative staff, leaving both physicians and patients frustrated? Dealing with soaring malpractice rates even as medical salaries have plateaued? Peer group consulting gives a medical practice a cost-effective way to find solutions to these issues – because the solutions have been tested in other business settings.

Keep the following in mind when considering peer group consulting:

• *Cost* – Is the annual cost quickly recoverable? Is membership priced so that you can quickly recoup the cost through better practice management?

• *Membership base* – Beware of groups that accept anyone. Look for peer groups requiring members to be a primary decision-maker in the business with years of experience. Groups with members straight out of business school and no operating experience offer less expertise.

• *Leadership* – Successful peer groups are led by a moderator with significant business experience, an understanding of group dynamics and leadership. Peer groups led by a moderator without operating expertise are bound to be free-for-alls.

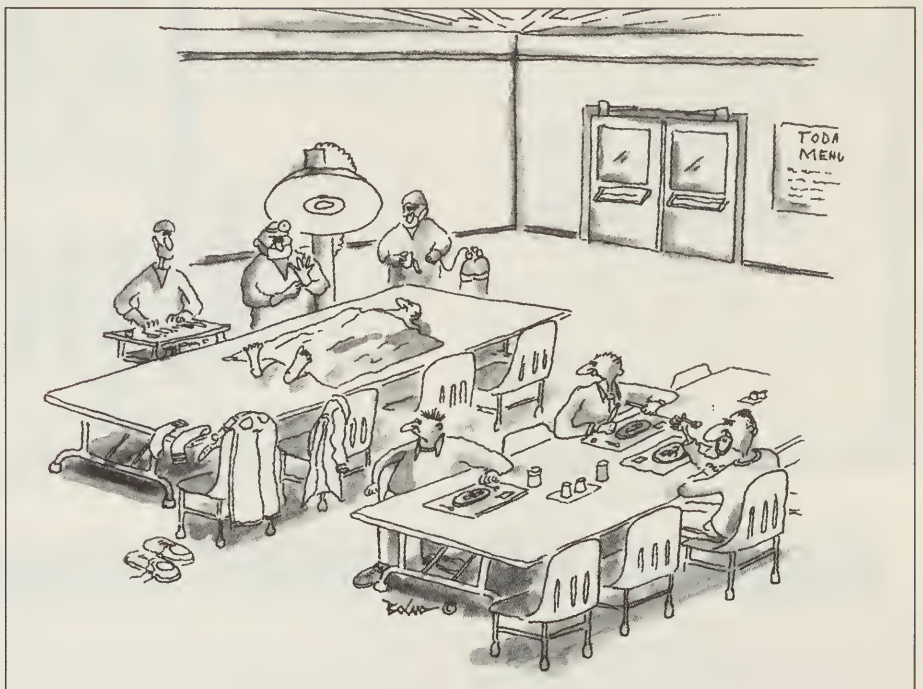
• *Time demands* – Know your limit of availability – time is money. A group that demands too much of your time is missing the point. At the same time, as part of a peer group, you are expected to share your expertise and experience with the other members.

• ***Avoid networking groups disguised as peer consulting*** – Look for a group that requires members to leave their sales pitches at the door. You don't need accountants peddling you their wares because you're trying to figure out how to control overhead costs.

• ***Diversity*** – Groups with members from many different industries are most likely to offer "been there, done that" solutions. Medicine has experienced things bankers haven't and bankers have seen things physicians haven't.

As the medical profession continues to change, so will the challenges faced by physician practices. While there are no simple answers to every issue, there is much to be learned from peers in other fields.

Thomas Bookey is president of Inner Circle, a peer group organization for entrepreneurs in Chicago. ■



"He must be on the cafeteria plan."

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Vaginal birth after cesarean

Julia Anderson-Miller

Deciding when it is right

BY JOY LE VEE

The growth in popularity of vaginal births after a cesarean (called V-BACs) has reopened the discussion on when to deliver babies surgically vs. vaginally and revived cautions physicians should take regarding patient safety and potential malpractice liability.

David Cromer, MD, chairman of the Department of Obstetrics and Gynecology at Evanston Northwestern Healthcare, said there is growing concern among obstetricians nationwide.

"Hospitals associated with our perinatal center are looking again at the safety of V-BACs," he said. "When V-BACs first became accepted practice, they were recommended only at the larger hospitals that were fully equipped to respond to emergencies such as uterine rupture. But as this restriction became more relaxed, we started to hear about some adverse outcomes for both mothers and babies, even when the patient was closely monitored during labor," he said.

The "once a cesarean, always a cesarean" way of thinking began to change gradually about 30 years ago as improvements in obstetric care made labor safer for both mother and child, according to the October 1998 issue of the ACOG Practice Bulletin, published by the American College of Obstetricians and Gynecologists to aid practitioners in making decisions about appropriate obstetric and gynecologic care. Before then, a mother switching to vaginal birth was believed to carry an inordinate risk of uterine rupture, which can be life threatening for both the mother and the infant, or may lead to hysterectomy for the mother and neurological impairment for the baby.

The development of the low-transverse incision for cesarean surgery made uterine rupture much less common in future deliveries. In 1981, when the V-BAC rate was only three percent, the National Institutes of Health began to encourage trial of labor.

More recently, controls introduced by third-party payers and managed care organizations – some mandating that all enrollees who have had previous cesarean deliveries undergo a trial of labor – have influenced the trend toward vaginal birth, ACOG states.

The bulletin recommended that most women who had a low-transverse incision from a previous cesarean delivery and who have no contraindications for vaginal birth are candidates for a trial of labor.

However, global mandates for a trial of labor after a previous cesarean delivery are inappropriate because individual risk factors are not considered, according to ACOG.

The organization reports that recent efforts to reduce the overall cesarean delivery rate have focused primarily on elective repeat cesareans because they account for one-third of the total c-sections.

According to ACOG, 27.5 percent of women who had a previous cesarean attempted vaginal birth in 1995, and most published series reported about 60 percent to 80 percent were successful at it.

However, when labor was unsuccessful, there were more maternal and infant complications than in cases of elective cesareans, leading some experts to caution that the pendulum should not swing too far in the opposite direction when V-BACs are involved.

Dr. Cromer encourages doctors to be a little more cautious, particularly with induction, and with women who have had more than one prior cesarean. Before making a decision, physicians should review the patient's previous obstetric records.

Adverse outcomes in V-BACs have led to malpractice suits, making the decision a potential liability issue for physicians as well as a patient-safety issue. The Physician Insurers Association of America recently began tracking data claims related to V-BACs. Although preliminary data are not yet available, Lori Bartholomew, director of loss prevention and research for PIAA, believes there have been few claims.

To reduce liability if something goes wrong, all risks should be discussed thoroughly with the patient, and discussions should be documented, Dr. Cromer said. "Some institutions are considering developing a separate patient consent form specifically for V-BACs."

Supporting Dr. Cromer's advice, Richard Donohue, an attorney who specializes in professional liability defense work for the Chicago law firm of Donohue, Brown, Mathewson & Smyth, said the most important factors in managing risk are patient selection based on the mother's medical and obstetric history, and an extensive, well-documented discussion with both parents (if possible) to make sure they understand the risks.

Despite continued concerns, many experts today agree that the benefits of vaginal birth after a cesarean outweigh the risks.

"Unless there are contraindications, I recommend that a woman who has had a previous cesarean be allowed to go into labor if she wants to," said Pedro Poma, MD, a Chicago Ob/Gyn and chairman of the Illinois ACOG section. He finds a surgical procedure is more risky for the mother. Uterine rupture occurs in less than one percent of the cases, he said. "Most women deliver with no trouble."

But Dr. Poma believes the decision ultimately should be made by the patient and her physician. "No woman should be forced to have a vaginal birth if she doesn't want it," he said. "Neither choice is absolutely risk free." ■

V-BAC advantages

- **Fewer blood transfusions.**
- **Fewer postpartum infections.**
- **Shorter hospital stays.**

Contraindications

- **Prior classical or T-shaped incision or other transfundal uterine surgery.**
- **Contracted pelvis.**
- **Medical or obstetric complications that preclude vaginal delivery.**
- **Inability to perform immediate emergency cesarean delivery because of unavailable surgeon or anesthetic, or insufficient staff or facility.**

Source: American College of Obstetricians and Gynecologists

MALPRACTICE ROUNDUP

Pennsylvania court says unless written, physician's guarantee not actionable

According to a March ruling by the Superior Court of Pennsylvania, patients have no cause of action against physicians who guarantee cures unless that guarantee is in writing. As discussed in the April 1999 issue of Medical Malpractice Law & Strategy, the ruling is founded in the Health Care Services Malpractice Act, designed to expedite the disposition of medical malpractice actions in that state. According to section 606 of the HCSMA, "in the absence of a special contract in writing, a health care provider is neither a warrantor nor a guarantor of a cure."

Section 606 was challenged when plaintiff Ronald Flora contended that his physician, George Moses, MD, failed to cure the plaintiff's diabetic foot infection. Flora began treatment with Dr. Moses after the physician diagnosed his peripheral vascular disease. To treat the infection, Dr. Moses prescribed periodic debridement and wet soaks to keep the area clean, as well as antibiotic treatments and auto-amputation of the toes on Flora's right foot. However, after dry gangrene of both feet developed, the plaintiff required below-the-knee amputations.

Flora sued Dr. Moses, contending that the physician had assured him that if he followed the prescribed course of treatment, amputation would be unnecessary.

According to the court, even if a guarantee by Dr. Moses could be assumed, it would have to be in writing to be legally actionable under the HCSMA. The court found that because there was no written guarantee for a cure or specific result, the plaintiff's claim was barred.

Delayed cesarean leads to $53.7 million verdict

A Staten Island, N.Y., jury awarded $53.7 million to Evan Giventer, who sustained permanent brain damage as a result of prebirth and post-birth delays in treatment, it was reported in the May 31 issue of the National Law Journal.

On Feb. 11, 1986, the child's mother went into labor, during which the fetal monitor indicated that the baby was in severe distress. The complaint alleged that a cesarean section was ordered but was delayed – first while the obstetrician finished performing surgery on another patient, and then because the anesthesiologist was unavailable.

According to the lawsuit, after the child was born, he needed to be put on a respirator but waited more than an hour to be intubated.

The parents sued the hospital, anesthesiologist, obstetrician and neonatologist, charging that negligence led to their son's disability. Except for the obstetrician, who settled for $3 million before the verdict was rendered, the defendants contended that the injury occurred before the mother arrived at the hospital.

The jury found the hospital 40 percent, the obstetrician 50 percent, and the neonatologist 10 percent liable (the anesthesiologist, though found to be negligent, did not cause the baby's problems, said the jury).

Child awarded $15 million for brain damage resulting from surgery

Alec Sears was born in April 1992 with a congenital heart defect. Corrective surgery consisted of a series of three operations, two of which were performed successfully that same year.

However, as alleged in Sears vs. Children's Hospital of Philadelphia, the third operation left him severely brain damaged. The surgery required that the child be put under deep hypothermic arrest, a process in which the body is cooled down significantly to stop the heart. As reported in the June 14 issue of the National Law Journal, the lawsuit alleged that the cooling-down process should take approximately 20 minutes, but that the surgeon accomplished it in nine minutes. Consequently, though the heart condition was corrected, the baby sustained severe brain damage during the operation.

As a result, the boy cannot walk, talk, see or sit up, and requires lifetime care.

The boy's parents sued the hospital, the surgeon and the anesthesiologist, charging that their negligence caused Alec's permanent brain damage. The defendants contended that the quick cooling followed an acceptable standard of care and that the child's neurological problems were not linked to the cooling process.

Nevertheless, on May 21, a Philadelphia jury awarded the boy $15 million and his parents $225,000. The jury found the surgeon 60 percent and the hospital 40 percent liable; although it also found the anesthesiologist negligent, the jury determined that his negligence did not cause the injury.

Neonatologist ordered to pay $6.9 million to blind girl

As reported in the May 31 issue of the National Law Journal, a Santa Ana, Calif., jury ordered a neonatologist to pay $6.9 million to a two-year-old girl who went blind shortly after birth. In Scott vs. Cigna Health Corp., the parents of Madison Scott sued Robert Hillyard, MD, charging that he failed to order a routine follow-up exam after the baby's premature birth and caused to be left untreated a condition – retinopathy of prematurity – "that is 95% curable if monitored," said plaintiffs' attorney Mark Hiepler.

Physicians who did not treat plaintiff are not liable under ostensible partnership

In Armato vs. Baden, a California case decided in April, that state's court of appeals held that physicians working as independent contractors are not liable based on an ostensible partnership theory for the negligent acts of a physician assistant employed by the corporation.

As reported in the May 1999 issue of Medical Malpractice Law & Strategy, Ann Armato fractured her wrist in 1994 and was referred to Managed Care Orthopedic Medical Group, solely owned by Robert Klapper, MD. Among the doctors at Managed Care were the defendants – four orthopedic physicians who worked as independent contractors, including Scott Baden, MD.

Upon presentation to Managed Care, Armato was treated by Rick DeLeon, a physician assistant. DeLeon ordered Armato's arm placed in a cast and subsequently prescribed physical therapy. Armato was never treated by any of the defendants.

In 1995, because her wrist had not healed properly, Armato sought treatment from Dr. Stark, a physician not associated with Managed Care. Dr. Stark told Armato her fracture had not been set. The plaintiff subsequently underwent surgery to repair the damage; however, the operation was not successful.

Armato first sued DeLeon, Dr. Klapper, and Managed Care for alleged negligent treatment. After settling with those three entities, Armato then filed a second suit against the four orthopedic physicians, claiming they owed her a duty to supervise DeLeon's care and were therefore vicariously liable for DeLeon's actions.

The trial court stated that there was no physician-patient relationship between Armato and the defendants and granted the defendants' motions for summary judgment; that decision was affirmed upon appeal.

In its analysis of the case, Medical Malpractice Law & Strategy states, "To be liable as an ostensible partner, the defendants would have to have acted in a way that would lead another person to believe that they were co-partners at Managed Care. . . . [Also, the defendants] had no contractual relationship with either Armato or DeLeon to treat Armato, they were not consulted in her care, and they did not represent to Armato that DeLeon was a physician. . . . Thus, there was no basis on which to impose liability on the defendant physicians for their own conduct or based on a vicarious liability theory for the actions of DeLeon."

Classified Advertising

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Seeking medical physician – Part-time position in new multidiscipline clinic. Competitive salary. Calls kept confidential. Call (847) 740-2800; fax CV to (847) 740-2802 or send to Scott G. Reiser, DC, 314 W. Rollins Rd., Round Lake Beach, IL 60073.

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Dental office space available to rent in Batavia, Ill. The 576-square-foot facility includes waiting room, 2 exam rooms, lab and restroom. Perfect for second office. Dentist occupying office for 30 years is moving out. $650 per month, includes all utilities. If interested, call (630) 879-0011.

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Dying

(Continued from page 3)

she stated. "For many young patients who get a dire diagnosis, death is just an option, not a reality. Some patients seem to think everything can be cured."

The evolution of the Springfield initiative comes at a time of increased scrutiny for physician handling of pain control and palliative care. A recent American Medical Association conference – Education for Physicians on End-of-Life Care – drew nearly 70 physicians to Chicago. The curriculum included strategies for dealing humanely with the terminally ill on multiple fronts.

Dr. Jackman admitted such training is sorely needed. Whether because of a lack of it in medical school, because a patient's death seems a personal defeat, or because death brings up emotional and spiritual issues with which physicians would rather not deal, there is currently an inadequate response by most medical professionals in the last stages of a patient's life. "We're not very good at bringing up these issues at the correct time," Dr. Jackman said.

Dr. Bretscher insisted that physicians "should come to see good end-of-life care as one of the biggest priorities in their practice. I don't experience feelings of failure when a patient dies. I experience them when I believe I did not do end-of-life care well. We must see our patients out of this life in a graceful, peaceful way that is personally enriching for them and for us."

Both physicians believe there are ways in which ISMS can take the lead in improving end-of-life care. "The Springfield initiative provides a model for the rest of the state," Dr. Jackman said. "And ISMS is an ideal conduit for its influence." She also sees ISMS becoming an informational storehouse providing a central intelligence bank for similar projects going on around the state.

Dr. Bretscher added she is gratified at the way in which the city of Springfield has embraced CICPCI. Mayor Karen Hasara and Rep. Gwenn Klingler (R-Springfield) both now serve on the initiative's board. Dr. Bretscher also went to the area's three hospitals, as well as the Southern Illinois University medical school, for volunteers. Their response was "overwhelming," and all the institutions are squarely on board, Dr. Bretscher reported – perhaps underscoring the growing realization by medical professionals that there is still much to learn about palliative care.

As the initiative moves into the uncharted waters of community involvement in end-of-life strategies, Dr. Bretscher encouraged individual physicians "to talk with patients about dying, preferably at the beginning of their relationships. Don't wait until there is bad news. Unless physicians bring up the subject, end-of-life discussions won't happen."

Dr. Bretscher also remains undaunted that central to CICPCI's success is a complete cultural shift in attitudes toward death. "The death of a Springfield citizen," she said, "is a community event, involving the patient's family, coworkers, church and the entire city. Medical professionals are there to help make it a good end for the patient. And at a certain point, the medical aspect becomes a very small part of it. We are there to help facilitate closure, to help people say goodbye. When dying is done right, physicians play a very small, unobtrusive role. We must simply learn when to get out of the way." ■

Quality initiatives the concern of IHCA July seminars

"HCFA's Quality Initiatives" is the topic of a series of seminars offered in July by the Illinois Health Care Association. Dates and locations are as follows:

- June 30 - Rend Lake (Seasons Lodge)
- July 1 - Springfield (Renaissance)
- July 28 - Naperville (Holiday Inn)

The seminars, given by HCFA representatives and industry experts, will review HCFA's quality initiatives, describe tools that measure their effectiveness, list key surveyor points and describe steps to improve survey results.

IHCA is the largest long-term care association in Illinois, representing 500 long-term care providers. Members include a variety of nursing facilities and residences as well as programs for developmentally disabled adults and severely disabled children.

For more information on the seminar, contact Amy Killam in the IHCA office at (800) 252-8988 (in Illinois) or (217) 528-6455, or e-mail info@ihca.com. ■

COLLECTIVE BARGAINING REPORT

Historic moments may impact physicians' fight for the right to bargain

➤ 1935: National Labor Relations Act passes.

Employees' right to collectively bargain is covered under the act, which was passed as the Wagner Act and subsequently amended under the Taft-Hartley Act. The act covers most private sector employees in the United States. Under its basic provisions, full- and part-time employees are automatically covered under the act and are given the right to negotiate their hours, wages and working conditions. Those rights apply to employees whether or not they actually belong to a union.

With doctors, the primary concern is on which side of the line they fall: are they employees or independent contractors? Physicians who work for hospitals or for academic health care facilities are considered employees.

Attorney Stephen Yokich of the Chicago law firm Cornfield & Feldman said that most physicians are considered independent contractors because they run their own practices, determine the number of patients they see, the amount of services they provide and the rate of reimbursement they receive. In those cases, the physicians would not be covered by the National Labor Relations Act.

➤ 1998: Doctors organize in New Jersey.

Five hundred physicians in Atlantic and Cape May Counties filed a petition with the National Labor Relations Board to be recognized as employees of an HMO so that they would then be eligible to join Local 56 of the United Food & Commercial Workers International union and bargain with AmeriHealth HMO.

The NLRB's regional director rejected the petition without even holding a hearing. The regional director determined that all the doctors were independent contractors with their own practices.

The physicians filed an appeal to the NLRB, and the board called for the regional director to hold a hearing to determine how much control the HMO had over the physicians' terms and conditions of employment. But on May 25, the regional director ruled that the doctors were independent businessmen because they ran their own practices, were free to contract with other HMOs and worked at their own offices. AmeriHealth, the director added, represented less than 5 percent of the doctors' patients.

STATUS: The union has not yet decided if it will appeal the decision to the NLRB.

ISMS General Counsel Saul Morse noted that the New Jersey case was not the best test case. The ideal lawsuit would involve a situation in which two or three health plans controlled a large percentage of the patients in a given area, and those plans were actively involved in utilization review.

➤ 1998: Antitrust action filed against Delaware physicians.

The Department of Justice brought antitrust action against the Federation of Physicians and Dentists, an affiliate of the American Federation of State, County and Municipal Employees. That union had attempted to use the messenger model in its negotiations between its independent physician members and Blue Cross/Blue Shield of Delaware. In that case, a third party acted as the go-between for physicians and payers by receiving and transmitting offers and counteroffers (the physicians are supposed to make decisions on contract terms individually). The DOJ countered that the messenger overstepped his bounds by coordinating contract terminations on behalf of the federation.

STATUS: The case is still pending.

Train

(Continued from page 1)

Who can be included in its membership is one of the main details to be investigated. Morse noted that although law in this area continues to evolve, currently, collective bargaining negotiations are limited to employed personnel. Antitrust laws prevent physicians who practice solo or in small groups from negotiating as a unit. "For the vast number of physicians at this time, it is not applicable to them," he said.

Another unanswered question is whether the Society legally is permitted to form a collective bargaining unit or if it must create a separate entity for that purpose. The answer may be affected by a May 24 U.S. Supreme Court ruling that the Federal Trade Commission has jurisdiction over not-for-profit associations such as ISMS. Morse said he believes this ruling greatly expands the possibility that the FTC will investigate or review the activities of not-for-profits, including the Society's initiative to form a collective bargaining unit.

The high court ruling won't prevent ISMS from forming a collective bargaining unit, Morse said, but it may be better for the Society to create an independent organization. ISMS has precedent in this area: In 1976 the Society helped form ISMIE, which was established as an independent insurance company.

The plan approved last month by the board was developed in response to a resolution approved by the ISMS House of Delegates at its 1999 Annual Meeting directing the Society to start a collective bargaining unit.

"Doctors need to move ahead, through their professional organization, in using the tools of federal labor law, to make ourselves heard on the key quality issues that demand our expertise," said ISMS President Clair Callan, MD.

Organized medicine will receive a boost from the actions of ISMS and the American Medical Association to support collective bargaining, according to Finley Brown, MD, a Chicago family physician. "We need organized medicine to take a stand. This will be good for patients," he said.

As a self-employed physician, Dr. Brown is not eligible to join an ISMS or AMA collective bargaining unit. New antitrust laws must be formulated, he said, and that is one of the AMA's companion projects to forming a national negotiating unit.

Although critics of collective bargaining say doctors want more money, Dr. Brown dismisses their depiction. Physicians want fair contracts with managed care companies and hospitals that don't compromise patient care by placing onerous restrictions on doctors, he said.

ISMS members are divided on the issue of collective bargaining, and several physicians made their positions known during the AMA's House of Delegates Annual Meeting in Chicago June 20-24. A solid majority of the AMA House of Delegates, including the Illinois delegation, subsequently voted to have the AMA form a national negotiating organization for employed physicians and residents.

The push for collective bargaining is a speeding train that many physicians have boarded, but the desired destinations will not work for everyone, said Jon Christofersen, MD, a general surgeon who is employed by Dreyer Medical Clinic in Aurora. "One of those destinations can be reached – being a union, negotiating salaries and working conditions for employed physicians." However, Dr. Christofersen noted that another destination – negotiating with payers – is prohibited by federal antitrust regulations.

Marc Schlesinger, MD, an ISMS delegate to the AMA, wanted to ensure that physicians fully understand the pros and cons. An amendment that he introduced and the House of Delegates adopted will require the AMA to educate physicians extensively about the limitations and advantages of a national negotiating organization. ■

COLLECTIVE BARGAINING REPORT

Q&A: Collective bargaining

The legal complexities of ISMS establishing a collective bargaining unit for physicians have left many observers confused about who can be included in a unit and how it will be structured. The following interpretations from ISMS General Counsel Saul Morse, and attorneys Gilbert Cornfield and Stephen Yokich of the Chicago law firm Cornfield & Feldman, provide insight into some of the questions surrounding this issue.

Q: How long would it take ISMS to form a collective bargaining unit?

A: The process begins when a group of employees signs cards authorizing the organization to be represented – 30 percent of the employees must agree to form a collective bargaining unit. However, if the employer wants to fight the process, it can take several years. Many employers try to show that individual union members are "managers" and should not be included in the union.

Q: Who would be covered to form or join a collective bargaining unit under the National Labor Relations Act?

A: Physicians who are employees are covered. Doctors who are employers /supervisors can join the unit, but they cannot be involved in negotiations. However, employers/supervisors enrolled in the unit could be challenged in court and used to thwart the collective bargaining unit. The National Labor Relations Board has had a long-standing policy that resident physicians are students, not employees, and therefore not entitled to protection under the NLRA. However, many experts believe the NLRB may overturn that policy when it rules on a request to allow Boston Medical Center residents to be considered employees and therefore be allowed to collectively bargain.

Q: What about physicians in independent practices? Can they be included in collective bargaining?

A: Solo practitioners are not considered employees and are therefore barred by antitrust laws from joining a collective bargaining unit.

Q: How can we change the current antitrust laws?

A: Lobbying for federal legislation is important. A bill that currently sits before the House Committee on the Judiciary would give physicians the right to collectively bargain, and groups such as ISMS and the American Medical Association have made lobbying for such physician-friendly legislation a top priority.

Q: Can states develop a legislative exemption to federal antitrust laws?

A: ISMS attempted to get such a bill passed 13 years ago. The bill failed, but ISMS will try again. Texas' governor recently signed an antitrust exemption law. The federal government could challenge that exemption. ISMS will continue to closely monitor its implementation.

Q: How do labor laws affect physicians who are set up as a corporation in a hospital?

A: There has been extensive organizing of such physicians in California and Arizona. If the doctors are major stockholders in the corporation, though, they may be considered employers, and as such, excluded from collective bargaining rights.

Q: If physicians are employed by a hospital and have formed an entity to negotiate their salaries, working conditions, etc. with the hospital, can that same entity negotiate with payers?

A: No, unless the physicians can establish that the HMO is the co-employer of the physicians, under the terms of the NLRA.

Q: If an HMO had 100 participating doctors and only three physicians were employees exclusively of that HMO, those three could bargain with the HMO. Does that mean any agreement the physicians reach with the HMO would extend to the other 97 physicians?

A: The HMO could extend those terms to the other physicians, but they would not be required by law to do so. ■

AMA

(Continued from page 1)

ating units, the AMA can use those data to begin its own efforts, rather than reinventing the wheel.

The AMA's Board of Trustees expects to have an action plan ready by the end of July, for a unit that will not strike or endanger patient care, but will give physicians leverage to guarantee that patient care is not compromised or neglected for the sake of profits, said Randolph Smoak Jr., MD, chairman of the AMA's Board of Trustees.

The AMA's resolution encompasses an array of powerful tools "committed to representing physicians in as many ways as possible," said Dr. Smoak. The tool kit includes the following strategies:

• The AMA will vigorously support antitrust reform that would give employed and self-employed physicians the right to negotiate. Currently, a national negotiating unit applies only to about 100,000 of the AMA's 290,000 members, noted Nancy Dickey, MD, AMA immediate past president. The proposed Quality Health-Care Coalition Act of 1999, now before the House Committee on the Judiciary, would provide relief from antitrust laws by allowing joint negotiations between physicians and health plans. E. Ratcliffe Anderson Jr., MD, the AMA's executive vice president, testified in favor of the bill during a committee hearing June 22. The bill faces fierce opposition from insurers as well as the federal government, so the AMA urges all physicians to call their Congressional representatives and ask them to support the bill. If that bill fails, the AMA will pursue new legislation.

• The AMA will work with the Department of Justice and the Federal Trade Commission to break down antitrust barriers on physicians.

• The AMA will provide state medical societies with model legislation and information on the state-action doctrine, which provides immunity for certain collective bargaining activities performed by physicians. Texas, for instance, successfully passed state-action legislation this year that will allow groups of physicians to negotiate with insurers and health plans under the guidance of the state attorney general.

• The AMA will continue to advance its private sector advocacy programs. Dr. Callan pointed out that the AMA already has a little-known but highly effective Division of Physicians and Patient Advocacy that performs numerous services such as exposing and eliminating abusive and unfair contracting provisions and management practices, negotiating with health plans on behalf of doctors and challenging national managed care mergers to prevent further consolidation of power. An AMA rapid-response team is formed on a case-by-case basis to resolve specific problems.

• The AMA will continue to support the formation of independent house staff organizations for residents who are not eligible to belong to a collective bargaining unit. In addition, the Association will be prepared to implement a national labor organization for residents if the National Labor Relations Board determines that residents are authorized to organize under federal law. This initiative hinges on the outcome of a petition on behalf of residents at the Boston Medical Center that asks the NLRB to hold that residents are employees and therefore entitled to collectively bargain under federal law. For residents authorized by state law to collectively bargain, the AMA will immediately implement a national labor organization to support local negotiating units. ■

Ted Grudzinski/AMA

GOV. GEORGE RYAN urges physicians to take an active role in organ donation during an address to the American Medical Association House of Delegates meeting in Chicago last month.

New laws

(Continued from page 1)

allows health care professionals such as self employed physicians and small groups of physicians to negotiate collectively with health care plans. The bill is in the House Committee on the Judiciary, where it has majority support. E. Ratcliffe Anderson Jr., MD, executive vice president of the American Medical Association, testified in support of the bill before the Judiciary Committee on June 22. The AMA will continue this summer to press for passage. At the same time, ISMS, with the assistance of the AMA, will work with Illinois lawmakers such as Judiciary Committee chairman U.S. Rep. Henry Hyde (R-Ill.) to try to get this bill passed. ■

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OID SAFETY: A CASE IN POINT (PAGE 6)

Illinois Medicine

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BIOTERRORISM ALERT

Detecting the signs

PAGE 9

ISMIE

What we have here, is a new way to communicate

PAGE 6

Federal patient rights fight continues

BY PAULA KRAPF

The national debate on patient rights legislation – and possibly the last chance for broad-based managed care reform this year – has moved over to the U.S. House of Representatives.

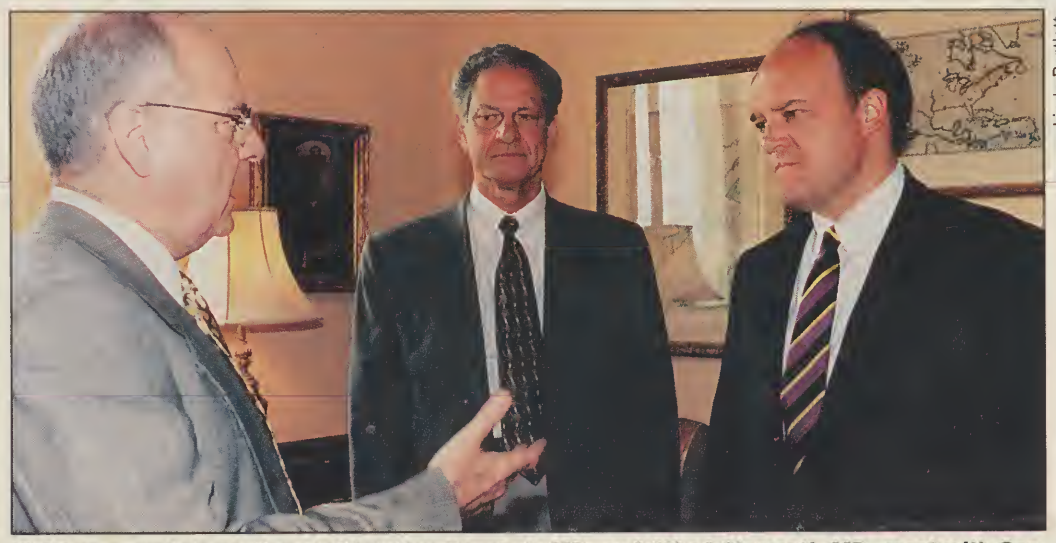
ISMS and the American Medical Association are relentlessly lobbying representatives to support a bill that provides considerably more patient protections than the Republican-backed version adopted by the Senate on July 15. ISMS and the AMA had endorsed a rival bill, which offered more comprehensive patient protections.

"We were very disappointed with the outcome of the Senate's vote, which forces the issue over to the House and the specter of a presidential veto," said Arthur Traugott, MD, chairman of the ISMS Board of Trustees. Dr. Traugott and ISMS member Alfred Clementi, MD, traveled to Washington, D.C., prior to the Senate's vote to discuss strategy with U.S. Sens. Richard Durbin (D-Ill.) and Peter Fitzgerald (R-Ill.).

Although the Senate's debate is over for now, ISMS and the AMA have turned their sights to the House. A patient rights bill cosponsored by Reps. Tom Coburn, MD (R-Okla), and Charles Norwood, DDS (R-Ga.), is an acceptable alternative to the Democratic bill that didn't pass in the Senate, said Dr. Traugott. While in Washington, he and Dr. Clementi also met with U.S. Rep. John Shimkus (R-Ill.) to discuss the bill and its prospects.

The House should take up patient rights legislation some time before its Aug. 6 recess, said an AMA spokesperson. Debate was originally scheduled to begin during the week of July 19, but proceedings were delayed due to the deaths of Rep. George Brown (D-Calif.), the oldest member of the House, and John F. Kennedy Jr.

(See Federal, page 8)



Linda Bartlett

ISMS representatives (from left) Arthur Traugott, MD, and Alfred Clementi, MD, meet with Sen. Peter Fitzgerald (R-Ill.) in Washington, D.C.

Senator heroes

Although the U.S. Senate failed to deliver a solid federal patient rights bill during its recent health care coverage go-around, the blame does not rest on the two Senators from Illinois, according to ISMS President Clair Callan, MD.

"U.S. Sens. Richard Durbin (D-Ill.) and Peter Fitzgerald (R-Ill.) were champions for legislation that would extend basic rights to patients and hold HMOs accountable for their actions," she said.

Fitzgerald withstood the most intensive lobbying since he came

(See Heroes, page 8)

Final edition

Illinois Medicine will cease publication after this issue, as ISMS turns to speedier communication tools to keep members informed.

The change is part of a new strategic plan adopted in April by ISMS that calls for aggressive outreach strategies to learn members' needs and to convey to them what the Society is doing on their behalf.

Reaching those goals means the Society will be fully utilizing the new communication modes, such as fax and e-mail, that have become widely available in recent years.

Already, the Society's Web site reports ISMS news just moments after it happens. Newsletters, faxes and e-mails will be added to the Society's communications repertoire. Faster communications means ISMS will be able to serve its members better.

Members are encouraged to have their fax number and e-mail address listings at ISMS up-to-date. Also, members should drop in often at www.isms.org to receive Society updates.

ISMIE, the Illinois State Medical Inter-Insurance Exchange, is also launching a new communications plan to replace the ISMIE Update section that regularly appeared in this publication. See page 6 for further details. ■

Physician throws his hat in the ring for Illinois House

Salvi surname gives political neophyte immediate boost in McHenry County's GOP territory

BY PAULA KRAPF

Illinois' House of Representatives lacks an important ingredient in the health care debate: A physician's voice. Armed with a politically-known family name and a boatload of enthusiasm, Thomas Salvi, MD, is determined to change that fact. A board-certified internal medicine specialist, Dr. Salvi will run as a Republican in November 2000 for state representative in the 63rd District, McHenry County, held by Rep. Jack Franks (D-Woodstock).

Nearly 400 health-care related bills are introduced in the Legislature each year, but there is no physician legislator during key moments in House floor debates, Dr. Salvi noted. "It's a shame because the General Assembly was established to represent regular citizens from all walks of life – farmers, teachers, lawyers and even doctors – but it doesn't. I want to change that."

(See Salvi, page 11)

Andrew Corrigan Halpern

Thomas Salvi, MD

INSIDE

Illinois' HIV reporting under way

Confidentiality central to surveillance system

July 1 marked the beginning of a two-year pilot program by the state that requires physicians to report cases of HIV infection to the local health department using a patient code number.

The program was established by the Illinois Department of Public Health to improve its ability to monitor emerging trends in the HIV epidemic.

ISMS file photo

John Lumpkin, MD,

IDPH has required the reporting of AIDS cases since 1981; however, because of new treatments for HIV, fewer people with HIV infection are developing AIDS. For this reason, counting only AIDS cases no longer provides an accurate picture of the number of people living with HIV.

Accuracy is important "to determine the level of need for HIV/AIDS health care and other services, to apply for federal funds that are awarded based on the number of HIV/AIDS cases, and to allocate resources for prevention and care programs," said John Lumpkin, MD, director of IDPH.

Under the new program, physicians assign a unique patient code number to each patient who tests positive for HIV (see story at right).

Besides reporting HIV cases to their local health department, physicians are required to maintain a system linking the patient code number to the patient to enable epidemiologic follow-up and provision of partner counseling and referral services.

The code number system was created to address privacy concerns that were raised in response to IDPH's proposal last year to report HIV cases by name to public health authorities. Consequently, of the 55 communicable diseases that must be reported, HIV infection is the only one reported without patient names.

The IDPH will evaluate the HIV surveillance system between Jan. 1, 2001, and July 1, 2001, to determine its effectiveness. If the system has failed to meet established criteria, reporting by name will be become mandatory July 1, 2001.

Questions regarding the new requirement may be directed to your local health department or to IDPH's HIV/AIDS surveillance unit at (217) 524-5983. ■

How are patient code numbers developed?

Physicians are required to report HIV cases treated or diagnosed after July 1. To prevent cases from being double-counted, a code number is developed using bits of personal information. The code consists of the following elements:

The first and third letters of the patient's last name; the number of letters in the last name (up to nine); the alphabetic code for the patient's gender; and the month, day and year of the patient's birth.

For example, the patient code number for John Doe born on July 4, 1976, would be DE3M07041976.

Elder abuse reports climb with new law

The number of suspected elder abuse cases reported statewide rose by about 11 percent in the first six months since mandated reporting took effect last January, according to the Illinois Department on Aging.

The number of cases reported in fiscal year 1999, ending in June, was 7,134, compared with 6,247 in the previous year.

For the first time in Illinois, the new law, the Elder Abuse and Neglect Act, requires physicians and many other professionals to report to the state within 24 hours of suspecting abuse, neglect or exploitation of an older person.

Reporting by professionals is required in situations in which, because of dysfunction, the elder is unable to do the reporting. Previously, such reports were voluntary.

The reporting requirement is limited to those older persons whom professionals see in the normal course of carrying out their duties.

Suspected elder abuse can be reported simply with a local telephone call. The Oak Park-based Suburban Area Agency on Aging is one of the agencies to which such reports can be made.

In partnership with the Illinois Department on Aging, the SAAA has arranged for community-based senior service organizations to intervene, investigate, provide respite care and domestic help and otherwise take steps to relieve abusive situations.

Lesley Janusz, elder rights specialist with the agency, emphasizes that the purpose of the reporting is not to punish suspected offenders but to provide help.

She recommends that callers provide the intake counselor with as much information as possible about the abused person as well as the individual(s) suspected of doing the abusing. Although specifically trained professionals will undertake a thorough investigation, the more help the reporter can provide, the sooner the problem can be resolved, said Janusz.

The new protective measure applies to a wide range of professionals, including physicians, nurses, psychologists, dentists, accountants, opticians, pharmacists and veterinarians, as well as law enforcement and social service professionals and anyone who cares for people age 60 and older.

To educate professionals on their new reporting obligation, the SAAA will hold one-hour briefings on Aug. 3, 4 and 5. For more information, call (800) 699-9043.

Telephone reports of suspected elder abuse can be directed to the SAAA at (708) 383-0258, the Illinois Department on Aging's Senior HelpLine at (800) 252-8966 during regular business hours, and the After-Hours Elder Abuse Hotline at (800) 279-0400. ■

Last chance to renew your license this year!

July 31 marks the expiration date for all Illinois medical licenses. Physicians should have received a license renewal notice from the Illinois Department of Professional Regulation.

Anyone who has not received that notice or has questions regarding renewal should contact IDPR at (217) 782-0458.

The Illinois State Medical Society has negotiated a 90-day grace period for renewal. However, if a physician's license is not renewed within that grace period, it will be considered expired as of July 31.

Requests for license renewal forms can also be faxed to the department's Licensure Maintenance and Technical Assistance unit at (217) 782-7645 or sent through its Web site at http://www.state.il.us/dpr.

Physician HELPline

ISMS' 24-hour Physician HELPline is available to link impaired physicians and their families with helpful resources.

Contact the HELPline at (312) 580-2499.

As near as your phone

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Physicians fight to regain autonomy from physician practice management company

Glen Ellyn Ob/Gyn Joseph Nigro, MD, describes his practice as a medical version of the disaster-plagued Titanic.

Following Glen Ellyn Clinic's sale to a physician practice management company nearly four years ago, physicians anticipated the new owner would steer a straighter course for the struggling clinic.

On October 31, 1995, many of the physicians at the DuPage County practice optimistically entered an arrangement with Caremark International. Caremark's representatives said their company would purchase the assets of Glen Ellyn Clinic and, through their management of the clinic, reduce operating costs and improve business operations. In turn, Caremark would receive a percentage of the clinic's net income. The doctors could then concentrate on providing quality patient care.

Nearly four years later, on June 9, 1999, seven physicians filed a complaint in Cook County Circuit Court against the clinic's current owner, MedPartners Inc. (MedPartners purchased Caremark in 1996, less than a year after its agreement with Glen Ellyn Clinic took effect.) In essence, the complaint charges MedPartners with misleading the physicians with false promises and failing to live up to those promises.

The suit also charges Glen Ellyn Clinic and MedPartners with inappropriately establishing restrictive covenants for the physicians. If any of the clinic's 160 physicians leave the clinic, they cannot practice in DuPage County for two years. For that reason, the doctors want their employment contracts voided before the clinic changes ownership again.

A spokesperson at MedPartners said the company has not seen the complaint and therefore declined to comment.

There will be a new owner eventually: In the fall of 1998, after its PPM business nationwide began collapsing, MedPartners announced that it was going to divest all of its PPMCs to concentrate on its pharmaceutical business. Some of the clinic's doctors may try to buy the practice back, although Dr. Nigro says taking that action would be like jumping on to a sinking ship.

"The physicians want to have their contract nullified so they can be free agents with the ability to bargain with whomever they want," said attorney Steven Harris, a partner in the Chicago law firm Harris Kessler & Goldstein.

The courts abhor restraint of trade and look for reasons not to enforce restrictive covenants, added Harris. "The reason for the courts' view is that the more competition there is, the more favorable pricing is for the general population."

(See Autonomy, page 7)

Takin' it to the streets

Kevin O. Mooney

At the busy downtown Chicago intersection of Clark and Lake Sts., Paul Ray, DO, discusses health concerns with Hernan Rios (below), who took advantage of "Passport to Wellness," a three-day men's health fair sponsored by the Illinois Department of Public Health. The program was offered last month to raise awareness of the importance of preventive health behaviors and the early detection and treatment of health problems that affect men. Dr. Ray, shown above next to the mobile health examination vehicle, was among the physicians participating in free cholesterol and blood pressure testing as well as screening for prostate cancer.

As part of the fair, the U.S. Postal Service also unveiled a new prostate cancer awareness stamp designed to encourage men to discuss with their doctors the need for regular prostate testing and examination.

The case against MedPartners

The Cook County Circuit Court complaint filed on June 9 by seven physicians at Glen Ellyn Clinic against MedPartners Inc. contains the following six counts (only one count names the clinic as well as MedPartners):

• Improper fee sharing. This count charges MedPartners with violating the Illinois Medical Practice Act. The act stipulates that physicians can share fees only with their physician partners, physician corporation or physician association or with another physician who also provides patient care. Therefore, MedPartners cannot charge a 15 percent "cost management fee" to the physicians at Glen Ellyn Clinic. The complaint notes that the dangers of fee-sharing include the fact that a physician may feel obligated to provide unnecessary treatment because of the need to share fees. The management company may overschedule patients to boost its share of the revenues, or otherwise interfere with the physician-patient relationship.

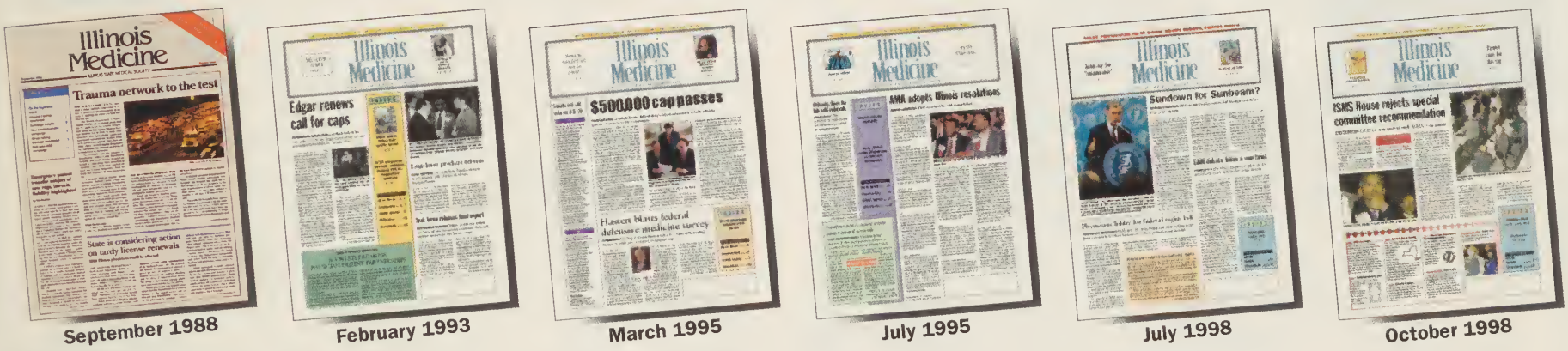
• Improper corporate practice of medicine. This count charges that MedPartners is not qualified to practice medicine in Illinois. The Illinois Medical Corporation Act specifies that only those licensed under the Illinois Medical Practice Act can provide medical or surgical treatment, consultation or advice to employees of a medical corporation. MedPartners' own registration statement, filed with the Securities and Exchange Commission in 1996, noted that many states have laws that "prohibit physicians from splitting fees with non-physicians and prohibit non-physician entities from practicing medicine." The filing adds that "there can be no assurance that the existing organization of the Company and its contractual arrangement with affiliated physicians will not be successfully challenged as constituting the unlicensed practice of medicine."

• Invalidity of the restrictive covenant. This count charges that Glen Ellyn Clinic currently lacks the authority to enforce restrictive covenants because it failed to maintain its license with the Illinois Department of Professional Regulation. And since MedPartners is trying to sell all of its PPM businesses, it has no right to enforce any restrictive covenants.

• Consumer fraud. This count

(See MedPartners, page 7)

Publishing good "Medicine" through the years



September 1988 February 1993 March 1995 July 1995 July 1998 October 1998

Over the past 11 years, Illinois Medicine has been the proud face of the Illinois State Medical Society. Whether covering news about managed care or physicians who care, Medicaid or AIDS, legislation or government regulation, the publication recorded the events that impacted the profession of being a doctor.

As Illinois Medicine draws to an end (see page 1), we offer a sentimental look at some of its past issues – starting with the maiden voyage in September 1988.

We also extend a heartfelt thank-you to the many dedicated contributors – writers, photographers, editors, artists, production assistants, advertisers and support staff – who made this newspaper a respected resource for news about Illinois physicians.

Illinois Medicine

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EDITORIAL

The patient rights beat goes on

As some folks drop back into the lazy, hazy, slower pace of summer, ISMS has been immersed in the heat of a mostly partisan political battle to have a strong and effective federal patient rights bill passed by Congress.

If the words "patient rights battle" sound all too familiar, that's because it was just a little more than one month ago that the Society was embroiled in an intense, and ultimately successful, campaign to win patient rights reform in Illinois. Now the focus has moved to the federal level.

As the debate began to unfold in the U.S. Senate earlier this month, Society leaders flew to Washington, D.C., to lobby key Illinois members of Congress on the matter. When the dust settled, the Senate Republican leadership celebrated a victory over supporters of a more comprehensive approach to patient rights advocated by ISMS and the American Medical Association. One major shortcoming of the Republican bill is its failure to establish an external appeal system that is fair to patients and independent from health insurance plans and HMOs.

Despite that setback, the Society salutes U.S. Sens. Richard Durbin (D-Ill.) and Peter Fitzgerald (R-Ill.) for championing patient rights in Congress. Durbin and Fitzgerald, for example, have continually supported a change that would give patients the right to sue their HMOs for faulty medical decisions. In this recent go-around, Fitzgerald opposed his own party to cast a key vote that allowed an open airing of the Democratic patient rights bill.

The debate now moves to the House, where, as of press time, the Committee on Commerce was about to begin discussions on this issue. As always, grassroots lobbying is essential to ensure that physicians' voices are heard. Doctors must contact their congressmen and tell them that the Senate language fails to guarantee a truly independent, binding and fair external appeals process. Specifically, legislators must learn that:

- Language is needed to ensure that an external reviewer's decision is not bound by a health plan's narrow definition of "medical necessity"
- External reviewers should not be selected only by the health plan
- Only doctors of the appropriate specialty should conduct an external review
- The reviews should be completed within 72 hours for urgent care, 30 days for nonurgent cases

Physicians cannot take a vacation from legislative advocacy. Together, organized medicine – state societies working hand-in-hand with the AMA – can win passage of a meaningful federal patient rights bill in the weeks and months ahead.

PRESIDENT'S LETTER

Meeting's message: Physicians are not going to take it anymore

Clair Callan, MD

The American Medical Association's Annual Meeting has come and gone. The message delivered there was the same as that delivered at the ISMS House of Delegates' Annual Meeting: physicians are tired of being underrepresented and powerless in their practice of medicine. Despite the concerns about the impact on professionalism and our image with the public, the overwhelming feeling was that we had to do something to give us greater say in how medicine is practiced.

It's not the money; it's the right to say "this is how medicine should be practiced, this is how patients need to be treated, this is how the managed care environment is having a negative impact on the health of the general public." It's the right to be listened to and to be heeded. It's time that the real issues are discussed and the business side of medicine stops hiding behind the smokescreen of physician cost.

HMOs and insurance companies are in the business of making money. Their CEOs do very well as a result of their success in this business. Patients are the ones who are most affected by the restrictions of managed care. Physicians are frustrated as these restrictions become more onerous, making it difficult to provide good care. And we are tired of being portrayed as the bad guys.

Maybe now, after the AMA's decision to approve collective bargaining, the business side of medicine will acknowledge that we do mean to be heard – and even that we may have a good point to consider.

The reality is that collective bargaining is an option limited to employed physicians. Most ISMS members are self-employed, and current antitrust law does not allow this category of physicians to negotiate fees. Therefore, we have to try to change the laws.

One ray of hope is the Quality Health-Care Coalition Act of 1999, (HR 1304), also referred to as the Campbell bill after its chief sponsor, Rep. Tom Campbell (R-Calif.). This proposed legislation would change the antitrust laws to allow independent self-employed physicians to collectively negotiate with HMOs and other health care insurers.

> *"It's not the money; it's the right to say 'this is how medicine should be practiced.' "*

The AMA is strongly in support of this bill, lobbying for it in Congress and encouraging physicians to contact their representatives to emphasize its importance. Participating in this endeavor will give you the chance to extend the "adopt a legislator" campaign to those who represent us in Washington, D.C., as well as those who represent us in Illinois.

So please do your bit: pick up the phone today and call the AMA grassroots hot line at (800) 833-6354 to be put through to your senators and/or representative at no charge. It's easy, and if we all do it, it should be very effective.

Thank you for doing your part; our future is in your hands. And thank you for your membership recruitment efforts. We are getting some new members, as well as some former members returning to the fold.

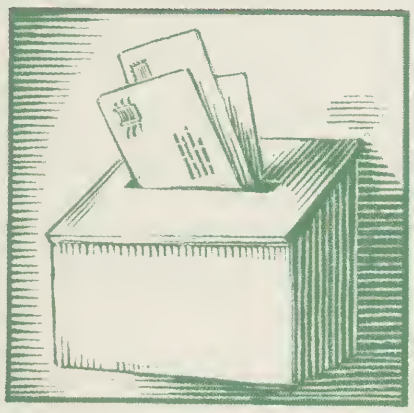
As I have said many times, numbers count. Our legislative successes this year have had an impact on all physicians. We can be even more effective if we represent more physicians. With your help, we can demonstrate to potential members that ISMS is important to them and to their patients.

LETTERS

Notwithstanding flaws, don't give up on organized medicine

As a delegate representing the DuPage County Medical Society, I have attended the ISMS Annual Meetings for approximately 10 years. Each year I think about resigning this position, but each year after the meeting I am refreshed and reassured that it is an honor to participate.

This last meeting, however, was extremely painful and upsetting. As most of us probably know, our membership has declined considerably. ISMS is down almost 3,000 members. The main reason for physicians leaving ISMS, it appears, is the direct link to the American Medical Association.



This year a thorough and articulate presentation was made by Arthur Traugott, MD, chairman of the ISMS Board of Trustees, regarding the finances of the Society. Upon completion of Dr. Traugott's presentation, it was clear that the most effective and reasonable solution was for ISMS to deunify from the AMA. Personally, I do not have a position on the matter; I think there are pros and cons to both sides. However, my ultimate concern is the survival of ISMS and, in turn, DCMS.

To the dismay of a majority of the ISMS delegates, the resolution calling for deunification from the AMA did not pass. As a result, it is anticipated that membership will continue to decline and additional debt will be incurred. The vote against deunification was quite shocking to most of us at DCMS.

We all need to know that as the membership declines and the current members age, the survival of ISMS is in jeopardy. The thing is, we know what life is like in this country, state and county with the current medical societies as they exist. What we don't know is what life would be like without organized medicine. I strongly believe we do not want to find out. I can assure you the trial lawyers are ecstatic over our current situation.

I realize I am essentially preaching to the choir. However, I do ask that those of you who read this letter talk to your family, friends and colleagues who are physicians who have recently discontinued their membership in organized medicine and encourage them to reconsider their decision.

No organization is perfect. We do have some bad apples; however, from my personal experience, it is clear that the majority of people in organized medicine are extremely dedicated. Most of us offer our time and efforts freely.

As I mentioned earlier, this last ISMS Annual Meeting was extremely disconcerting and discouraging. It is tempting to just throw up our hands and give up on organized medicine altogether. I'm sure that that is exactly what the trial lawyers and payers hope we will do. In fact, I suspect they already have the party planned. But I strongly believe that giving up is exactly what we should NOT do.

Stuart A. Morgenstein, DO
Bloomingdale

Thank you, Sen. Fitzgerald

Despite heavy pressure from the insurance industry and business interests, U.S. Sen. Peter Fitzgerald (R-Ill.) cast an important procedural vote in favor of openly debating patient rights legislation in the Senate. ISMS mobilized physicians to thank the senator for his support.

The following letter, signed by ISMS President Clair Callan, MD, was sent as a "Letter to the Editor" to Illinois newspapers.

Thank you Sen. Peter Fitzgerald for standing up for what is right and voting to allow fair and open debate on the "Patients' Bill of Rights." This crucial piece of legislation will extend basic rights to patients and help restore confidence in our health care system.

The reforms contained in S6 are very much in line with a bill recently passed here in Illinois, the "Managed Care Reform and Patient Rights Act." Both bills put matters of medical necessity back in the rightful hands of patients and their doctors. Illinois consumers asked for this legislation.

A federal law would serve to further strengthen this resolve and send a strong message to insurers that deliver inadequate care.

Bravo to you Sen. Fitzgerald! Thank you for supporting the health care needs of your constituents here in Illinois. We wish you continued success in your fight for patient rights.

Clair Callan, MD
ISMS President

..."Our speaker today was the first practitioner in the country to be credentialed in paperwork."

Upcoming ISMIE seminar

AMBULATORY CARE: FERTILE GROUND FOR MALPRACTICE LIABILITY EXPOSURES

Nov. 16, Oakbrook Terrace

Call (800) 782-4767, EXT. 1627

ISMIE Update

Upcoming ISMIE seminar

RISK MANAGEMENT: AN ESSENTIAL OFFICE PRACTICE

Sept. 24, Lisle

Call (800) 782-4767, EXT. 1627

Serving up a new communications plan

An open letter to ISMIE policyholders

For the past few years, there have been tremendous changes in health care delivery. Obviously, such change greatly impacts the insurance needs of physicians. ISMIE has continually been cognizant of these changing needs, and has been proactive in enhancing and expanding its products and services accordingly. Many of ISMIE's coverages and services are considered cutting edge in the medical malpractice industry. In fact, the only thing that never changes at ISMIE is its "Physician-First Service."

Through Illinois Medicine, the ISMIE Update has been an important communications vehicle, keeping policyholders and others up to speed on issues related to medical professional liability in general and ISMIE in particular. Feature articles have provided timely risk management advice, often on matters many physicians may not have thought of in that context: prescription risks, protection of and access to medical records, wrong-site surgery prevention initiatives, and much more. ISMIE coverage expansions and enhancements have also been regularly reported.


ISMIE

WHEN IT MATTERS MOST

ISMIE's Quarterly Publication of Policyholder News

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Volume 1 Number 1 August 1999

COVERAGE ENHANCEMENTS

As the premier provider of professional liability insurance to physicians in the Midwest, we strive to offer products which maximize protection and minimize worry. Our goal is to ensure you with the best coverage at the most affordable price. We know that as your practice environment has changed, your professional liability coverage protection must adjust to meet your relevant needs. In that context, we are pleased to offer the following policy improvements as of July 1, 1999.

Enhanced Tail Coverage

We are pleased to announce a significant change to our retirement tail provisions. Effective this July, ISMIE will offer free retirement tail to any physician, at any age, as long as the physician has been insured with ISMIE for ten consecutive years. This feature should be of considerable value to you and your fellow physicians. Naturally, our other retirement tail feature, which requires a minimum age of 55 and 5 consecutive years of coverage with ISMIE will be retained.

Expanded Coverage

Your practice is growing and expanding. Because of this, we are broadening our policy territory to include the United States, its territories or possessions, Puerto Rico or Canada as long as any claim brought against a physician is pursued in these jurisdictions. This is a considerable broadening of the policy territory which currently includes only Illinois and the contiguous states including Michigan.

Legal Expense Reimbursement

Your medical license is a key component of your ability to practice your profession as a physician. When the Illinois Department of Professional Regulation (IDPR) begins an investigation against you, the conse-

(Continued on page 3)

ISMIE PHYSICIANS EMPLOYMENT PRACTICES LIABILITY (EPLI)

New, Lower Premiums Now Available...

In their role as employer, physician practices are commonly subjected to the risks of lawsuits stemming from employment practice matters such as wrongful termination, sexual harassment, and age, race or disability-related discrimination. These lawsuits relate not to medical care – but to administrative and managerial practices. This liability exposure is known as Employment Practices Liability (EPL).

(Continued on page 4)

The new plan

As part of ISMIE's physician-first service and commitment to its policyholders, we are changing the way we communicate to better meet those needs. Instead of relying on one or two primary communications vehicles, we will be communicating with policyholders in a variety of forms – newsletters, faxes, e-mails, and a new Web site.

Specifically, new items include:

✔ Beginning this fall, policyholders will begin receiving an ISMIE quarterly newsletter – be sure to watch for it! The newsletter will include general ISMIE information about new policies, changes to existing policies, notices of upcoming ISMIE seminars and events, CME opportunities, legal updates, clarifications of policy provisions and company-specific information. Because we understand physicians' time constraints, newsletter articles will be presented in a concise, easy-to-read format. A sneak peak at the newsletter's new design format is shown on this page.

✔ A new ISMIE Web site – www.ismie.com – will be launched soon. Here, policyholders will be able to receive information about ISMIE's coverages, products and services 24 hours a day, seven days a week. There will be numerous opportunities for on-line interaction, and the quarterly newsletter also will be posted on the site.

✔ Understanding that ISMIE's policyholders are diverse in many ways, we will also provide targeted newsletters geared to particular practice demographics, including specialties, practice locations and practice types. These newsletters will include risk management information, legal updates, relevant case examples, CME opportunities and seminar listings. Formatted in a succinct style, this communications expansion will ensure we are meeting all physicians' specific information and insurance needs.

We know you have found ISMIE Update to be useful and informative and we are confident that you will find our new communications provide you with the information you need, in a convenient format, when it matters most.

Harold L. Jensen, MD, ISMIE chairman

Documenting informed consent an essential part of steroid therapy

BY MARGARET VEACH

CASE IN POINT

Steroids are often drugs of choice in treating patients with asthma and certain other conditions. However, serious side effects are associated with steroid use. The following cases highlight the importance of obtaining careful informed consent – and documenting that consent.

Case #1

The case in brief. This case involves a 45-year-old woman who developed avascular necrosis in her left hip as a result of an allegedly negligently prescribed steroid treatment for her asthma.

In July 1992, the plaintiff went to her doctor complaining of shortness of breath. The physician examined the patient and obtained a medical history, during which the patient told of having been on steroids 10 months earlier for a head injury sustained in an automobile accident. The physician also performed a pulmonary function test, which revealed borderline moderate-to-severe asthma. The doctor prescribed short-burst steroid therapy of 60 mg of Prednisone per day and requested the patient to return in two weeks.

The patient did not return until four weeks later, when she complained of pain in both hips and knees. She had completed the course of Prednisone, and a pulmonary function test showed that her asthma was much improved.

One month later, the patient called the physician, again complaining of arthralgia. The physician requested that she come in for a blood test for collagen vascular disease later that week. Her blood test was negative for collagen vascular disease, and a pulmonary function test showed good results.

The following month, the physician received a letter from a rheumatologist to whom the patient had gone with complaints of severe pain in her hips and knees. The rheumatologist advised the physician that imaging studies showed the patient had avascular necrosis. The patient later underwent a total replacement of her left hip.

The patient subsequently sued the physician for negligently prescribing Prednisone and not warning her about the risks associated with steroid therapy – particularly avascular necrosis.

At trial, the jury found in favor of the defendant physician on the basis that his prescribing Prednisone was within the standard of care. The jury also found that the avascular necrosis was not caused by short-burst steroid therapy; thus the doctor had no duty to warn the patient of that risk.

Case #2

The case in brief. A 27-year-old man went to a hospital emergency room in April 1994 complaining of chest pain, persistent cough and difficulty breathing. He was admitted to the hospital and given Solumedrol, a steroid, for possible allergic bronchitis.

Several days later, the patient's physician performed a bronchoscopy to rule out sarcoidosis. The results were negative. Diagnosing laryngeal

(See Steroids, next page)

Steroids

(Continued from previous page)

irritation from chronic post-nasal drip, the physician discharged the patient. She also discontinued the Solumedrol but wrote a prescription for Prednisone to be taken in tapering doses over the next four weeks.

Six months later, the patient went to another physician with a complaint of hip pain. The doctor's impression was that the patient had a history of excessive steroid use, possibly leading to avascular necrosis. An MRI, and later a biopsy, indeed showed AVN in both femoral heads.

The patient underwent total hip replacement of both hips that same year. He sued the physician who had prescribed the Solumedrol and Prednisone, alleging that she improperly diagnosed his condition and improperly prescribed an excessive dosage of steroids.

The jury returned a decision in favor of the plaintiff, finding the defendant physician negligent.

> *Even short-term steroid use, once thought to carry fewer risks, is now being considered as having a role in avascular necrosis.*

The points these cases make: Both cases demonstrate the need to fully inform the patient about risks associated with steroids, obtain the patient's consent to proceed with the therapy and document that consent.

"Steroids are a unique and powerful group of medications," said Richard Geline, MD, an orthopedic surgeon in Skokie and chairman of the ISMIE Risk Management Committee. "Nothing else is quite as effective in certain conditions requiring anti-inflammatory therapy. Nevertheless, the association between steroids and AVN is well known, and doctors have to tell their patients about that."

Even short-term steroid use, once thought to carry far fewer, if any, risks, is now being considered as having a role in AVN. "The question now is what dosages and routes of administration will carry the least risks of AVN," said Dr. Geline. He pointed out that inhaled and injected steroids were previously believed to remain local, unlike orally administered steroids; however, researchers are now studying whether they too eventually enter the bloodstream.

"Doctors should prescribe steroid therapy very conservatively," said Dr. Geline. "They should confine it to cases in which it is absolutely necessary. They also must explain the risks to the patient, obtain the patient's consent to proceed, and document that discussion."

Robert Baron, a partner with Rooks, Pitts & Poust in Joliet, agrees. "No matter what they are prescribing, I would give physicians the same advice: They must tell the patient about the most likely and the most serious side effects," said Baron. "It must be documented in the patient's record that the patient was told of the risks of AVN from steroids and yet elected to proceed with the therapy."

According to Baron, one cause of lawsuits involving prescription drugs is that doctors do not tell patients about any side effects whatsoever. "Then, when the patient reacts to the drug, the patient is surprised because he or she did not know what to expect," said Baron.

Case in Point uses hypothetical case histories to illustrate key risk management issues. ■

There's still time to attend a 1999 ISMIE seminar!

Only five months remain in ISMIE's 1999 calendar of seminar offerings, so if you haven't attended an ISMIE program yet this year, make sure to register soon. Seminar dates and locations are as follows:

- **Delegating Care to Non-Physician Practitioners: Who Is at Risk?** (Sept. 22, Oak Brook; Oct. 27, Collinsville; Nov. 17, Lincolnwood; Dec. 15, Springfield)
- **Risk Management: An Essential Office Practice** (Sept. 24, Lisle; Oct. 14, Rockford; Nov. 3, Chicago)
- **Pediatric Risk Management: It's Not Child's Play** (Sept. 28, Oakbrook Terrace)
- **Ob/Gyn Malpractice Claims: Clinical Keys to Reducing Loss** (Oct. 20, Northbrook)
- **Ambulatory Care: Fertile Ground for Malpractice Liability Exposures** (Nov. 16, Oakbrook Terrace)

The seminars vary from two and one-half to three hours in length and offer Continuing Medical Education credits. For more information, call (800) 782-4767, Ext. 1627.

Autonomy

(Continued from page 3)

"We had two weeks to decide if we would sign the Caremark contract," Dr. Nigro recalled. The physicians ultimately signed the contract that bound them to Caremark for 41 years, he said. Typically, PPMC contracts can run anywhere from 25 to 40 years, Harris said.

Meanwhile, many of the physicians had already signed restrictive covenants with Glen Ellyn Clinic. If any of those physicians had decided to bypass the Caremark contract, they would have had 90 days to establish a practice outside of DuPage County. "They didn't want to leave town in three months," observed Dr. Nigro.

Despite misgivings about signing the Caremark contract, Dr. Nigro signed on because four of his partners were governed by the clinic's restrictive covenant. "I felt that I had no choice because I did not want to leave my partners," he said.

Physicians who endorsed the new contract anticipated positive changes ahead under Caremark's management such as an infusion of capital and a new computer system for the clinic. However, the clinic did not thrive under Caremark's watch, and business operations declined even more after MedPartners took over, according to Dr. Nigro, and alleged in the physicians' court complaint. Overhead costs have almost doubled since 1995 while physicians' salaries have been cut nearly in half, said Dr. Nigro. "I'm not working any less, and my patient load is the same as when the contract took effect."

MedPartners also cut into the doctors' salaries with its management fee, which claims 15 percent of net revenues from the clinic, he said.

A few of the physicians at the clinic have told Dr. Nigro that they think the lawsuit against MedPartners is a good idea, but they are afraid to be named as co-plaintiffs. "This whole episode has been a tragedy," he said. ■

MedPartners

(Continued from page 3)

charges that MedPartners made false promises to the physicians in violation of the Illinois Consumer Fraud and Deceptive Business Practices Act. For instance, MedPartners said it would offer physicians access to capital, management expertise, sophisticated information systems and managed care contracts. However, volume contracting and purchasing never occurred, and MedPartners entered into HMO and fee- for-service contracts that were not economically beneficial to the physicians. Overhead expenses at the clinic nearly doubled while physicians' salaries have declined by approximately half since 1995.

• Common law fraud. This count charges MedPartners with misleading physicians about the benefits that would be derived from a contract between both parties, the effect upon operating costs such as overhead and physicians' salaries. Because MedPartners misled the physicians, they have suffered a loss of income while the clinic's operating expenses increased.

• Breach of contract. This count charges MedPartners with violating its contractual duties to the physicians by failing to provide the operating efficiencies promised, including the immediate reduction of overhead costs; failing to provide the agreed practice management services; undermining the practice's profitability and causing physicians' salaries to decrease.

Finally, the complaint asks the court to release the physicians from the restrictive covenants with Glen Ellyn Clinic and/or MedPartners. In addition, the physicians seek damages in excess of $50,000 as well as unspecified punitive damages.

A spokesperson at MedPartners said the company has not seen the complaint and therefore declined to comment. ■

National health survey comes to Cook County

Cook County has been selected to participate in the current National Health and Nutrition Examination Survey of the health and nutritional status of U.S. residents. A sample of approximately 450 people in Cook County will be asked to participate in the survey, being conducted from July 5 through September 23.

The NHANES program began in the early 1960s and has been conducted as a series of surveys examining a nationally representative sample of about 5,000 people selected from 15 different counties each year.

The cooperation of the medical community has contributed to the success of the program in the past, according to the Department of Health and Human Services. DHHS is striving to make health care professionals aware of the program so they can better answer patients' questions about the survey.

National Center for Health Statistics personnel will interview designated households and conduct physical examinations.

The detailed interview includes demographic, socioeconomic, dietary and health-related questions; the examination consists of medical and dental exams, physiological measurements, and laboratory tests carried out in specially equipped mobile examination centers.

Findings from the survey will be used to determine the prevalence of major diseases and risk factors for diseases, assess nutritional status and its association with health promotion and disease prevention, develop sound public health policy and direct and design health programs and services.

For more information, contact NHANES field operations at (800) 210-3413. ■

Federal

(Continued from page 1)

As the push for patient rights enters this new phase, ISMS and the AMA will insist that any package of patients' rights legislation include the following components not covered in the Senate's bill:

- The right to an independent and fair external appeal of health plan decisions
- The right to hold health plans accountable when their decisions harm patients
- The right to have physicians decide what treatment is medically necessary
- The guarantee that these rights apply to all U.S. citizens

ISMS and the AMA will champion only a patient rights bill that applies to all insured people, Dr. Traugott said.

"Any patient rights bill we support must not undercut what we have accomplished in Illinois with the managed care reform passed last spring," he added.

According to an ISMS analyst, if the GOP's bill became law, some of its provisions could undo a substantial portion of the Illinois bill, which Gov. George Ryan is expected to soon sign into law.

For instance, the GOP's bill establishes an internal and external appeals process for patients when medical care is denied. It is not clear, however, if this is truly an "independent" external review. Illinois' bill specifies that the external review be independent, and the patient must agree to the choice of the reviewer. Because the GOP's external review provision applies to all employer-provided group health plans, it is uncertain whether the federal provision could override the existing Illinois bill.

The following provisions are some examples of how the GOP bill falls short of the Illinois patient rights bill:

Emergency care: The GOP's bill makes it easier for patients to receive treatment from the closest emergency room, whether or not the hospital is in the patient's health plan. But the bill does not stipulate under what conditions the plans actually have to pay for ER coverage. It also is unclear whether the GOP's bill includes protections for post-stabilization services as Illinois' bill does.

Women's health: The GOP's bill would allow women to see a gynecologist for routine care or an obstetrician during pregnancy without getting a referral from a primary care doctor. It would prevent "drive-through" mastectomies in which women are forced out of the hospital hours after breast cancer surgery. Meanwhile, Illinois already has adopted a law that allows a woman to see her Ob/Gyn for all care, not just narrowly defined "routine care." In addition, Illinois previously passed a law to prevent drive-through mastectomies.

Gag rules: The GOP's bill states that health plans cannot forbid doctors from discussing all treatment options with a patient. Illinois' bill specifically prohibits gag practices as well as gag clauses and charges health care providers with giving full and complete information to their patients, regardless of the economic interests of their health care plans. ■

ISMS file photo

Sen. Richard Durbin (D-Ill.) (right) spoke in favor of HMO liability on the floor of the U.S. Senate during the recent patient rights debate.

"The insurance companies do not want to be held accountable for their actions. They hate the idea of being sued in court as the devil hates holy water. They want to be protected so they can make the wrong decision when it comes to medical care for American families and never be held accountable."

Heroes

(Continued from page 1)

to Washington, D.C., in January as he bucked his own party leadership to press for a bill that, among other things, included HMO liability.

"I'm glad to have this week behind me," Fitzgerald said on July 16, following four days of debate that ended with the narrower Republican version of patient rights passing the Senate.

Pressure on Fitzgerald began to mount early on when he crossed party lines to help kill an attempt to table the Democratic version of patient rights legislation. A letter from Dr. Callan thanking Fitzgerald for "standing up for what is right and voting to allow fair and open debate on patient rights" was sent to newspapers across the state. (See page 5 for the complete text of the letter.) ISMS also mobilized Illinois physicians to thank both of the state's Senators for their leadership on patient rights.

Although Fitzgerald characterized the persuasion to vote with Republicans on that first proposal as "very strong," he said it paled in comparison to the "very, very, very strong pressure" that followed as the health care debate progressed. "I was pressured by insurance companies, every major company in the state, and also the [Republican] leadership."

The sticking point gluing Fitzgerald to the opposite party was that the Democrats' bill contained the right to sue HMOs and insurance companies that act negligently. "I made it clear that I had supported during my campaign legal accountability for HMOs," he said. "The Republicans offered an amendment to strip the ability to sue HMOs that harm people out of the Democratic bill. That amendment passed and I was one of two Republicans who voted no."

The freshman senator took in stride the developments that threw him into the national limelight on this issue. One published report quoted a GOP lobbyist calling Fitzgerald a "major threat" to the Republican bill.

"I was perceived to be a critical swing vote. But realistically, the Democrats needed to pick up more Republicans than me and [U.S. Sen. John] Chafee [R-RI] if it was going to pass."

A last-minute compromise that would have imposed liability fizzled for lack of support, Fitzgerald said. "It just had Democrats, me and John Chafee." ■

Q&A: Sen. Fitzgerald

U.S. Sen. Peter Fitzgerald (R-Ill.) recently crossed party lines to support Democratic-sponsored patient rights legislation backed by organized medicine. The Republicans' narrow and weak version eventually passed the Senate and awaits action in the House. In an interview following the vote, Fitzgerald provided analysis into the mostly partisan debate on patient rights.

Q: Why did you prefer the Democratic bill over the proposal from your own party?

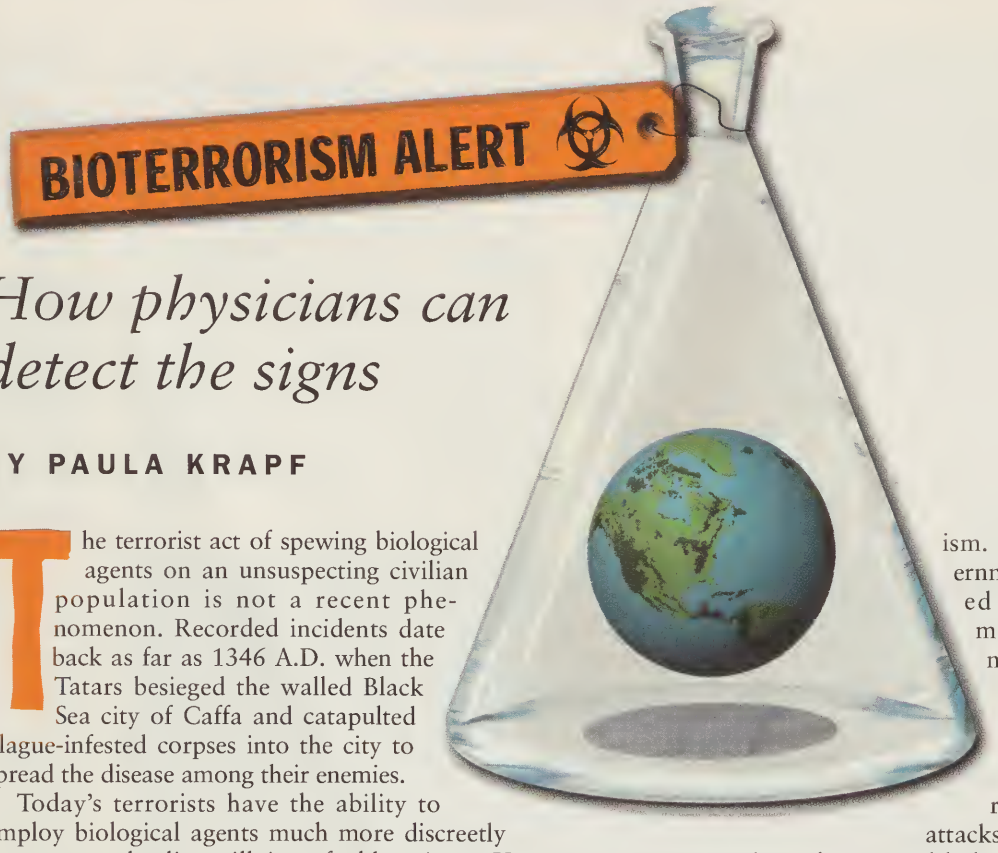
A: "The real sticking point was the right to sue HMOs in the Democratic bill but not in the Republican. I believe the immunity from lawsuits HMOs enjoy is unjustifiable. I think their behavior would improve if they were accountable when they behave negligently."

Q: What good could come of the Republican bill if the President won't sign it?

A: "I wouldn't feel so confident the President won't sign the bill. He has said that many times and changed his mind. He said that about the Y2K limits on liability and changed his mind; he also said he would veto the aging national missile defense system and he signed it."

Q: Will the weaker bill the Republicans supported hurt the party politically?

A: "I don't want to be a political pundit; I'd rather analyze the legislation. I do think there were some improvements gained by the GOP bill. External appeals would have to be wrapped up in 72 hours; none could take longer than 30 days. It's unclear what the House will do from here."



How physicians can detect the signs

BY PAULA KRAPF

The terrorist act of spewing biological agents on an unsuspecting civilian population is not a recent phenomenon. Recorded incidents date back as far as 1346 A.D. when the Tatars besieged the walled Black Sea city of Caffa and catapulted plague-infested corpses into the city to spread the disease among their enemies.

Today's terrorists have the ability to employ biological agents much more discreetly than corpse-hurling villains of olden times. Unsuspecting commuters in a Japanese subway in 1995 became ill when Sarin gas was intentionally cast through a transit tunnel. On a smaller scale, diners at several Oregon restaurants in 1984 experienced food poisoning when terrorists, intent on altering an election outcome, infected salad bars with Salmonella.

Such attacks highlight how tough it could be to promptly identify a covert man-made biological attack and how vulnerable our society is to bioterrorism. The federal government has responded by allocating more than $120 million for state and local public health departments to begin formulating a response to such attacks.

Because the substances likely to be used in a bioterrorist attack cause symptoms very much like those experienced with the flu, one facet of the readiness response is to teach the medical community how to tell them apart.

"We're in the midst of a time when these events are occurring, and there are a lot of questions that need to be addressed," said Pam Diaz, MD, medical director of communicable diseases for the Chicago Department of Public Health. Dr. Diaz presented an overview of what physicians should know about bioterrorism and biological agents at the recent Midwest Clinical Conference.

Dr. Diaz said physicians should suspect a biological weapon has been disseminated if they observe:

- A single, definitively diagnosed or strongly suspected case of a disease in a patient with no risk history who therefore would be unlikely to have the disease
- A cluster of patients who present with a similar syndrome, such as an unusually high number of influenza cases, a remarkably high number of influenza cases in vaccinated individuals or a particularly high influenza morbidity or mortality rate in younger patients
- An unusual disease or a disease that is uncommon to a particular geographic area
- An unexplained increase in a common syndrome, above seasonally expected levels, such as a high number of influenza cases in the summertime

"Biological agents appeal to terrorists because there is a low risk of detection and only a small amount is required to affect millions of people," Dr. Diaz noted. The agents are easy to obtain and inexpensive to purchase. In addition, the perpetrators can vaccinate themselves and be protected against the agent they disperse, and the incubation period gives them time to escape. ■

Julia Anderson-Miller

Three top threats

A number of toxins and infectious disease agents can be used as biological weapons. However, a federal government task force has identified the three top threats as anthrax, smallpox and plague.

These agents qualified for the list based on several factors, including availability, how much death and destruction the various agents could wreak and which agents were best suited for a biological weapon. In particular, the experts believe perpetrators would be most likely to disperse the agent in aerosol form for an unsuspecting public to inhale, said Pam Diaz, MD, medical director of communicable diseases for the Chicago Department of Public Health.

Diseases such as anthrax don't normally show up in doctors' offices, so Dr. Diaz highlighted some facts physicians should know about the three top bioterrorist threats.

ANTHRAX During a bioterrorist event, anthrax would most likely be inhaled. The incubation period is a scant three to five days. If anthrax has been inhaled, the patient contracts a nonspecific flu-like illness. Then the patient may get better, but without treatment, he or she will soon go into severe respiratory distress.

"In general, an individual with anthrax may have a widened mediastinum, yet no primary pneumonia," said Dr. Diaz. Anthrax can be treated with antibiotics.

SMALLPOX Although this disease was eradicated worldwide, there is concern that a perpetrator could obtain an illegal cache, perhaps from stockpiles left in the former Soviet Union, and disperse it.

After a 12-day incubation period, individuals have flu-like symptoms that progress to a rash on the face, hands and forearms. Patients are infectious from the time the rash appears until the scabs have fallen off.

Smallpox is a potential threat because no one in the United States has been vaccinated for the disease since 1980, and there is little vaccine left, said Dr. Diaz.

PLAGUE This disease also begins as a nonspecific, flu-like illness. The patient eventually becomes severely ill, and can go into rapid shock and die if not treated early.

Pneumonic plague is the most likely form to be used in a bioterrorist attack. The organism grows slowly and may be misidentified, but a physician dealing with a severely ill patient who has no known risk factors should work with a laboratory to identify the disease, said Dr. Diaz. Pneumonic plague can be treated with drugs.

Smallpox and pneumonic plague present the biggest threats in cases of bioterrorism, because both can be transmitted person-to-person.

It may be difficult for physicians to determine whether an outbreak of a disease is the result of a bioterrorist agent or a natural event. However, physicians can keep these diseases in the back of their minds, conduct routine surveillance, and work with labs and local health departments to obtain the correct diagnosis.

"Whether it's natural or man made, our vigilance and our suspicion can help us decrease illness," Dr. Diaz said.

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Salvi

(Continued from page 1)

This is Dr. Salvi's first run for public office, and he intends to continue practicing as a physician if elected.

When Dr. Salvi officially announced his candidacy May 1, he said several health care issues motivated him to run for office, particularly managed care reform. He praised the passage in June of ISMS' Managed Care Reform and Patient Rights Act, but called it an important first step that needs watching. Doctors should have input on how that law affects practicing physicians and their patients, Dr. Salvi said.

For instance, he is concerned about the impact of a provision in which a committee reviews an HMO's denial of care. "It sounds great, but if a patient has a hip fracture and is denied rehabilitation by his HMO, he has to wait for the committee's review. That's too late, because the patient needs the rehabilitation now," he said.

A physician legislator is needed to continue the job of placing medical decisions back into doctors' hands, he said "It's terrible how involved managed care has become in such decisions as the kinds of tests we can order for patients and the length of their hospital stays."

Tort reform is another legislative initiative Dr. Salvi said he would aggressively pursue in the General Assembly. Illinois' 1995 tort reform law, strongly fought by trial lawyers, was struck down by the Illinois Supreme Court in 1997. Dr. Salvi would support ISMS' attempts to restore caps on lawsuits.

That pro-tort reform stance puts him at odds with his politically well-known brother, personal injury attorney Al Salvi, a former two-term state representative from Lake County and erstwhile candidate for statewide and federal offices. Brother Patrick Salvi, also a Lake County personal injury attorney, opposes tort reform, too.

The three brothers have a close relationship, according to Dr. Salvi, but they passionately defend their diverse views on that matter. "We're not allowed to discuss tort reform at the dinner table," admitted Dr. Salvi, who said the edict was issued by their mother.

Yet voters' familiarity with his brother Al should help Dr. Salvi win votes in the overwhelmingly Republican McHenry County. Although Al Salvi lost his bids for secretary of state and U.S. Senate, the conservative Republican handily won McHenry County in both of those races. The Salvi name recognition should scare off potential Republican primary challengers, which would free up Dr. Salvi to focus on the general election.

In addition, Dr. Salvi has the united backing of the Republican party's McHenry County leadership, unlike the fall 1998 House race when the party was bitterly divided into two factions. That chasm helped Democrat Jack Franks claim the majority Republican district, Dr. Salvi said.

Franks, who plans to run for a second term but has not formally announced his candidacy, will be a tough opponent, concedes Dr. Salvi, adding that he will need substantial funding to remain competitive. "If doctors are serious about having Springfield representation, then I'm going to need their financial backing," he said.

Dr. Salvi struggled with his decision to seek office, afraid that the medical community would be critical. Eventually he concluded if doctors want to play an active role in public policy, they should become public servants on behalf of physicians and patients.

"Patients don't have an active lobby, and they are counting on doctors to stand up for them. The political reality right now is that a lot of health care decisions are being made in Springfield – not in doctors' offices," he said. ■

Candidate profile

Name: Thomas Gerard Salvi, MD
Age: 35
Personal: Married to Gwen; 4 children
Occupation: Board certified internal medicine specialist and partner for Fox Valley Internal Medicine, with offices in Crystal Lake and Lake in the Hills
Political party: Republican
Office sought: Illinois House of Representatives, 63rd District
Activities: President of the McHenry County Medical Society
Key issues: Continue work on the Managed Care Reform and Patient Rights Act and other managed care issues; seek solutions to onerous government regulations; increase physician reimbursement; tort reform
Reason for running: To ensure there is a doctor's voice providing perspective in the health care debate because the Legislature considers hundreds of health care related bills every year that directly impact doctors' practices
Web page address: www.tomsalvi.com

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